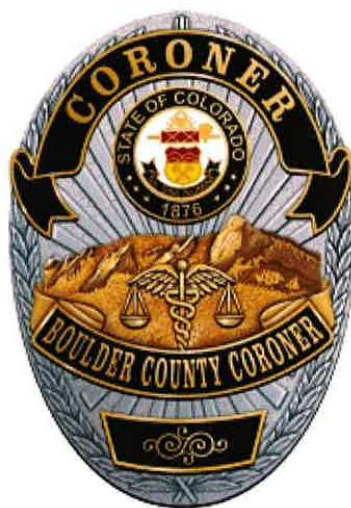




2014 ANNUAL REPORT

BOULDER COUNTY CORONER'S OFFICE



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Office of the Boulder County Coroner

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To the Citizens of Boulder County,

I am pleased to present the 2014 annual report from the Boulder County Coroner's Office. The report highlights the activities of the office and offers a valuable resource to understand the work we do and emerging trends in the county.

The 2014 caseload was consistent with the elevated level of 2013. There was a slight decrease in scene responses, but the overall number of autopsies was comparable. The sustained increase in cases continued to be a challenge for the office, but the staff worked hard to provide the citizens of Boulder County with the highest quality service.

An emerging trend during 2014 was the increase in the number of transient/homeless deaths in the city of Boulder. Due to the increase and the interest by city policy makers, I prepared a mid-year report analyzing these deaths compared with the 3 previous years. The 2014 causes of death for this population were: accidental—8 cases (42%), natural—8 cases (42%), undetermined—2 cases (11%), and suicide 1 case (5%). Amongst the accidental and undetermined rulings, 20% were due to alcohol and hypothermia, 50% were due to drugs and/or alcohol intoxication, 20% were due to hypothermia, and 10% were undetermined causes.

Child deaths increased in 2014 as well. Of the 14 child deaths in 2014, 5 of them were Sudden Unexpected Infant Death (SUID) type deaths, 4 of which had findings of unsafe sleep environments at the time of death. Due to this increase and the emerging need to advocate for safe sleep environments for infants in Boulder County, a 10 year study of all sleep related deaths of infants in Boulder County was conducted for the inclusion in this annual report.

Coincidentally with the increase in child deaths, the state mandated that, starting January 1st, 2015, each county form their own Child Fatality Review and Prevention Team to review child deaths of un-natural causes, starting with 2014 case reviews. The Coroner's Office collaborated with Boulder County Public Health, in an effort to bring all required agencies together and was ultimately asked by Public Health to become the coordinator of the team on behalf of their department.

It was also an honor to continue the offices's community and professional outreach this year by teaching and presenting to CU Law School students, the Colorado Coroner's Annual Conference and the New Coroner's Institute. Solving John Doe cases continued to be a priority. During 2014, I visited John Doe gravesites in the county with the hopes of continuing our success during 2013, when we successfully identified one of the John Doe cases.

Excitingly, 2014 also marked the groundbreaking for the new coroner's building. This stand-alone modern facility consolidates all operations in a central location to enhance the services the office provides, and creates a much improved work environment for the staff.

I am honored and proud to have served another year for the citizens of Boulder County.

ERHall

EMMA R. HALL
Coroner

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INTRODUCTION

MISSION STATEMENT

The mission of the Boulder County Coroner's Office is to conduct thorough and fair investigations into deaths falling under its jurisdiction with professionalism and integrity to determine the manner and cause of death, in a timely manner. The core values of the office are integrity, excellence and compassion; the office is committed to maintaining the integrity of the investigations it conducts by setting high standards of accountability and preserving confidentiality, the office is committed to serving with excellence by establishing and preserving community trust through professional conduct, the office is committed to providing compassion, dignity and respect for the deceased and their families.

FUNCTION OF THE OFFICE

The Office of the Boulder County Coroner is a creation of the Colorado Constitution and the Colorado Revised Statutes §30-10-601 through 621. Under those statutes the Coroner is required to make all proper inquiry regarding the cause and manner of death of any person under his/her jurisdiction.

The cause of death may be defined as the disease or injury that resulted in the death of an individual. Examples of causes of death may include: "heart disease", "pneumonia", "gunshot wound", or "blunt force trauma". The manner of death is a medico-legal term that describes the circumstances of an individual's death, and is an opinion based on the "preponderance of evidence". When a natural disease process, such as heart disease or diabetes, causes death, the manner of death typically would be classified as **Natural**. The manner of death is classified as **Accident** when the death is the result of a hostile environment, and the event is not expected, foreseen, or intended. The manner of death is classified as **Suicide** when the person acts with the intent of causing his or her own death. When the death is the result of the killing of one human being by another, the manner of death is classified as **Homicide**. Homicide is a medico-legal term and should not be confused with such terms as "murder" or "manslaughter" which are used by the criminal justice system to describe the degree of criminal intent in a particular homicide. When there is insufficient evidence to determine the cause and/or manner of death, both the cause and manner of death may be classified as **Undetermined**. In other instances, the cause of death may be readily apparent, but the evidence that indicates manner of death may be equivocal, thereby leading to a manner of death of Undetermined. The manner of death is classified primarily to aid survivors in understanding the events surrounding an individual's death and for statistical purposes.

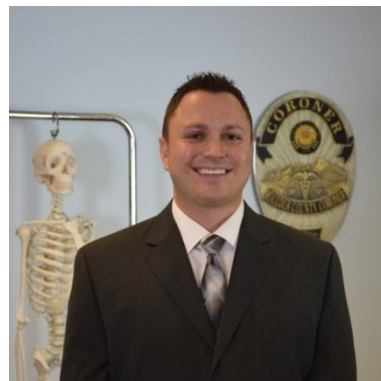
The 2014 staff of the Boulder County Coroner's Office consisted of the following:



Elected Coroner: Emma R. Hall. Ms. Hall is a Boulder County native who grew up in Lyons on Hall Ranch. She comes from a pioneer family that has been in the county since the 1870s. Ms. Hall is responsible for the day to day administration of the office as well as the daily management of cases. She is ultimately responsible for the determinations of cause and manner of death for the cases in which the office takes jurisdiction. Ms. Hall is a graduate of Niwot High School and Metropolitan State College of Denver, with a degree in Criminalistics (the study of evidence). Her background includes experience and training in death investigation, autopsies and forensic pathology, crime scene investigation, evidence analysis, elder abuse, child death investigation, blood stain pattern analysis, forensic anthropology, mass fatalities and emergency management, aquatic death and homicidal drowning. Ms. Hall is a certified Death Investigator and a member of the Colorado Coroner's Association. She co-chairs the Elder

Abuse Fatality Review Team with District Attorney Stan Garnett. Ms. Hall attends a number of meetings throughout the county and state to include Boulder County Elected Official/Department Head meetings, mass fatality planning meetings, fire and flood planning meetings, Boulder County Child Fatality Review Team meetings, Boulder County Law Enforcement Chiefs meetings, Metro Area Coroner meetings, and the Colorado Forensic Investigators meetings. Additionally, Ms. Hall sits on the Criminal Justice/Forensics Advisory Board at Arapahoe Ridge High School in Boulder. Emma's true passion in the field is being able to provide answers to as many questions as possible to the family in each investigation and to help the family in their healing process.

Chief Deputy Coroner: Dustin Bueno. Mr. Bueno is responsible for the day to day administration of the office and the management of the investigations staff. Mr. Bueno has several years of experience working in the field of medico-legal death investigation and private investigations. Mr. Bueno was previously a Deputy Coroner at Adams County Coroner's Office; as a supervisor and field training officer he created a death investigation training program, and wrote numerous office procedures. Mr. Bueno is experienced in assisting at autopsy procedures and has extensive training in toxicology, radiography, latent fingerprint collection and identification, and photography. Mr. Bueno has produced numerous educational presentations for law enforcement and the community, and he has taught on numerous career related topics.



Board Certified Forensic Pathologist: Michael F. Arnall, M.D., P.C., Forensic Pathologist. Dr. Mike Arnall is a triple board certified forensic pathologist with 30 years' experience in autopsies and death investigations. Dr. Arnall attended medical school in St. Louis, Missouri at the Washington University School of Medicine. He completed a fellowship in forensic pathology at the Denver County Coroner's Office, as well as a fellowship in surgical pathology at the Baylor College School of Medicine in Houston, Texas. Dr. Arnall has worked as a medical examiner and forensic pathologist in Florida, Massachusetts, New Zealand and multiple counties in Colorado. He has performed over 3000 autopsies and has testified as an expert in forensic pathology in over 200 homicide trials.

Board Certified Forensic Pathologist: **Robert A. Kurtzman, D.O., FCAP Forensic Pathologist.** Dr. Robert Kurtzman is a 1980 graduate of the Des Moines University College of Osteopathic Medicine and has been practicing medicine for 34 years. He is board certified by the American Osteopathic Board of Pathology in Anatomic Pathology, Laboratory Medicine and Forensic Pathology. He received his Forensic Pathology training under the direction of Dr. Werner Spitz at the Office of the Medical Examiner of Wayne County in Detroit, Michigan and continued to work in Southeast Michigan until he relocated to Grand Junction, Colorado in 1992. While in Colorado he has served as elected Coroner for Mesa County for two terms and as a contract Forensic Pathologist providing service to over 14 counties. His involvement in notable cases includes: the Northwest Airlines Flight 255 air disaster at the Detroit International Airport in 1987, Aspen ski accident death investigation of Michael Kennedy in 1998, Storm King Mountain fire forensic team in 1994 and the sudden death investigation of former Enron CEO Kenneth Lay.

Board Certified Forensic Pathologist: **Daniel C. Lingamfelter, D.O., Forensic Pathologist.** Dr. Daniel Lingamfelter is a 2004 graduate of University of North Texas Health Science Center. His post graduate training consisted of an Anatomic and Clinical Pathology Residency at the University of Missouri-Kansas City, and a Forensic Pathology Fellowship at the University of Texas Southwest Medical Center. Dr. Lingamfelter is board certified by the American Board of Pathology in Forensic Pathology, Anatomic and Clinical Pathology and has taught at the University of Missouri School of Medicine and at Texas Christian University. Dr. Lingamfelter has published many journal articles and has given many presentations throughout the nation and Canada.

Deputy Coroner: **Wendy Kane.** Ms. Kane has a Bachelor's Degree in Business Management and an Associate's Degree in Criminal Justice and Applied Sciences. She has over 9 years of experience in investigations as a police officer and is also a certified massage therapist. Ms. Kane previously worked for the Colorado Bureau of Investigations Unit and is trained in fingerprint identifications. Ms. Kane handles a portion of the caseload, as well as handling various day-to-day operations.

Deputy Coroner: **Angel Luehring.** Ms. Luehring is an army veteran who worked for the U.S. Army as a certified Medical Laboratory Technician and is currently finishing her Bachelor's Degree in Health Administration with an emphasis in Bio-med. Ms. Luehring handles a portion of the caseload, as well as handling various day-to-day operations of the office.

Deputy Coroner: **Brandon Dixon.** Mr. Dixon grew up in the Golden area and attended college at the University of Colorado at Denver. He graduated with a degree in history and has worked in the investigative field ever since. Mr. Dixon has five years' experience working in the private sector doing financial and insurance based investigative work prior to joining the coroner's office. Mr. Dixon handles a portion of the caseload, as well as, handling various day-to-day operation of the office.

Deputy Coroner: **Melinda Rose.** Ms. Rose is a Colorado native who was born and raised in Littleton. She graduated from Metropolitan State College of Denver in 2007 with a degree in Chemistry with a Concentration in Criminalistics. Ms. Rose completed an internship with the Denver Office of the Medical Examiner where she worked as an intern for the pathology department assisting with autopsies.

Deputy Coroner: **Andrew Muck.** Mr. Muck grew up in the Thornton area and is a Colorado native. Mr. Muck came from the field of mortuary science where he had experience with managing cremations, funeral services and performing as a funeral director. Mr. Muck has a strong background in working with families who have lost a loved one.

Deputy Coroner: **Derek Rinaldi.** Mr. Rinaldi is a Colorado native, born and raised in Lafayette and Boulder. He attended Metropolitan State University of Denver and graduated with a Bachelor's degree in Chemistry with a concentration in Criminalistics, where he also worked for the forensic anthropology department of the university updating and streamlining their standard operating procedures. Mr. Rinaldi additionally completed a year-long internship with the Denver Office of the Medical Examiner.

Pathology Assistant: **Cory Martin.** Ms. Martin joined the Boulder County Coroner's office in September of 2011 as an Autopsy Technician Intern and was subsequently hired upon completion of her internship. Ms. Martin holds degrees in opera performance from Indiana University, Bloomington, gemological certifications from the Gemological Institute of America and most recently, in 2012, she completed her bachelor's degree in biology from Metropolitan State University, Denver. Ms. Martin is responsible for the day to day operation of the morgue and assists at autopsies.

Administrative Supervisor: **Lorraine Dickes.** Mrs. Dickes has been active in the field of office management for twenty years. Her concentration has been in small companies managing accounting and payroll; she is content in the element of numbers. She has owned her own businesses including industries in farming, retail, construction and bookkeeping. Mrs. Dickes has had training with the US State Department in exporting, State of Colorado for Notary and Boulder County for Supervisor Certificate and Office Pro Certificate. She has received excellence awards and recognition from the United States Post Office.

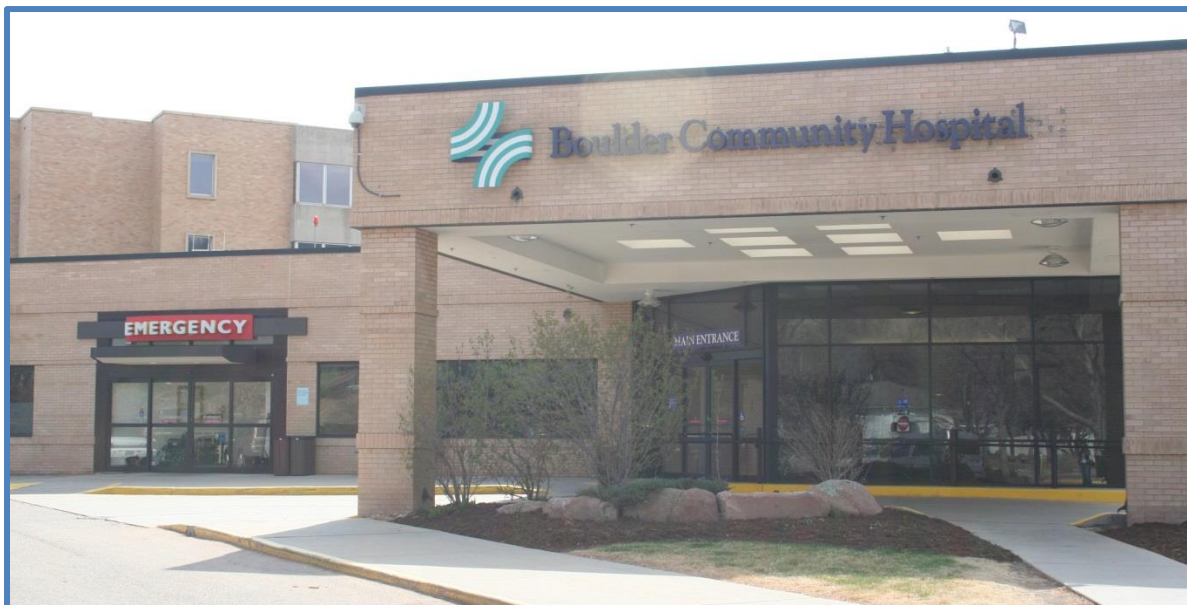
FACILITIES

In 2014 the administrative offices of the Boulder County Coroner were located in the Criminal Justice Center at 6th Street and Canyon Boulevard in Boulder. Groundbreaking for the new facility to be located at 5610 Flatiron Parkway occurred in March of 2014.



Location of Boulder County Coroner's Office.

In 2014 the Boulder County Coroner's Office utilized the morgue and autopsy facility at Boulder Community Hospital on a contract basis.



Location of Boulder County Coroner's morgue.

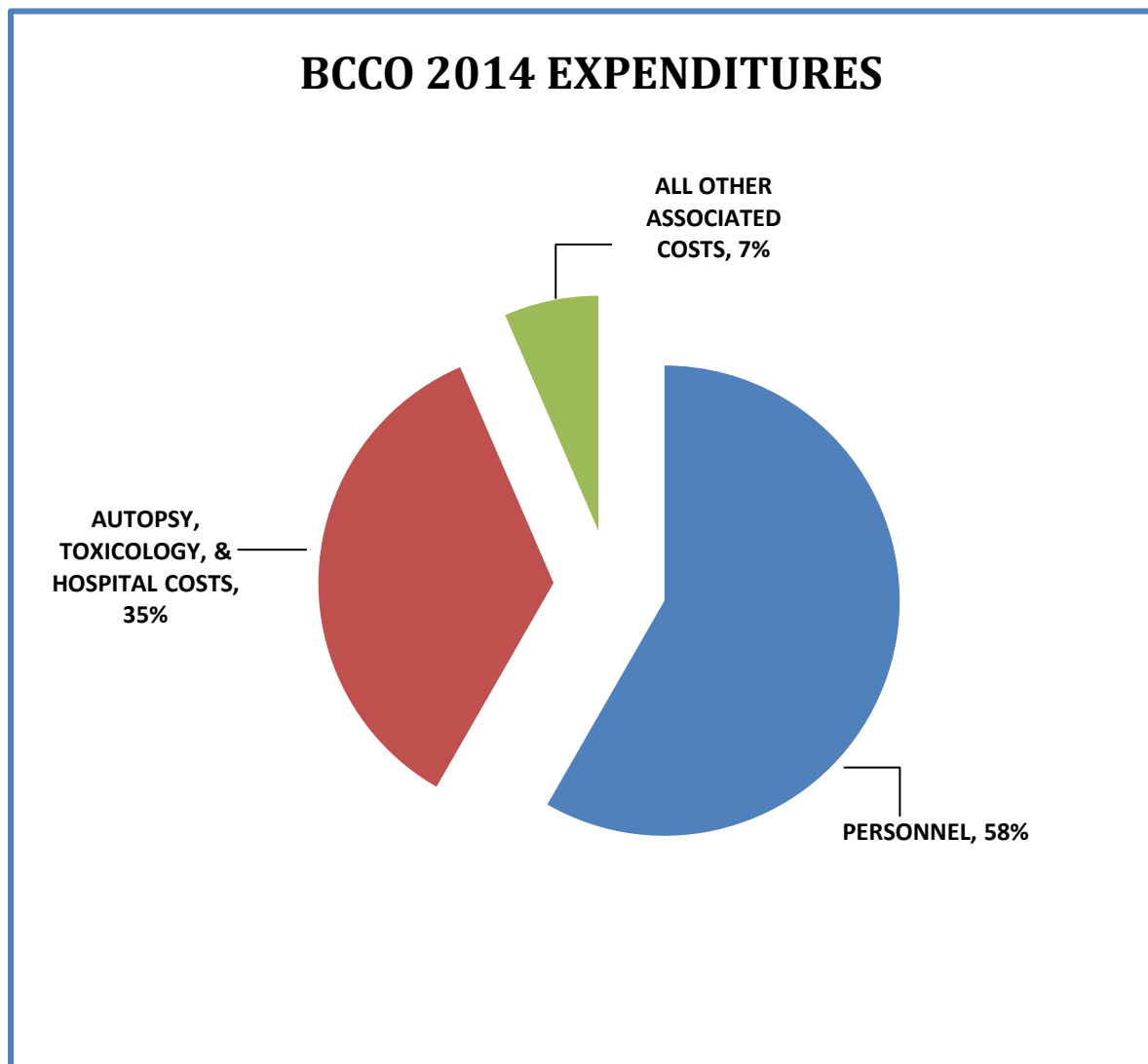
BUDGET

FUNDING

The funding for the coroner's office comes from the general fund. The general fund is the common use fund where the majority of the county's core services are funded. The coroner's office has an appropriation which is split between personnel and operating expenditures. The majority of the revenues that go into the general fund, include property tax, motor vehicle fees, recording fees, other fees and charges for service, interest on investments, and intergovernmental revenues. Additional information is available through the Boulder County Budget Office.

EXPENDITURES

The 2014 expenditures for the Boulder County Coroner's Office was \$1,030,637. This is 0.28% of the total adopted 2014 Boulder County budget of \$366,760,981.



DESCRIPTION OF REPORTABLE CASES

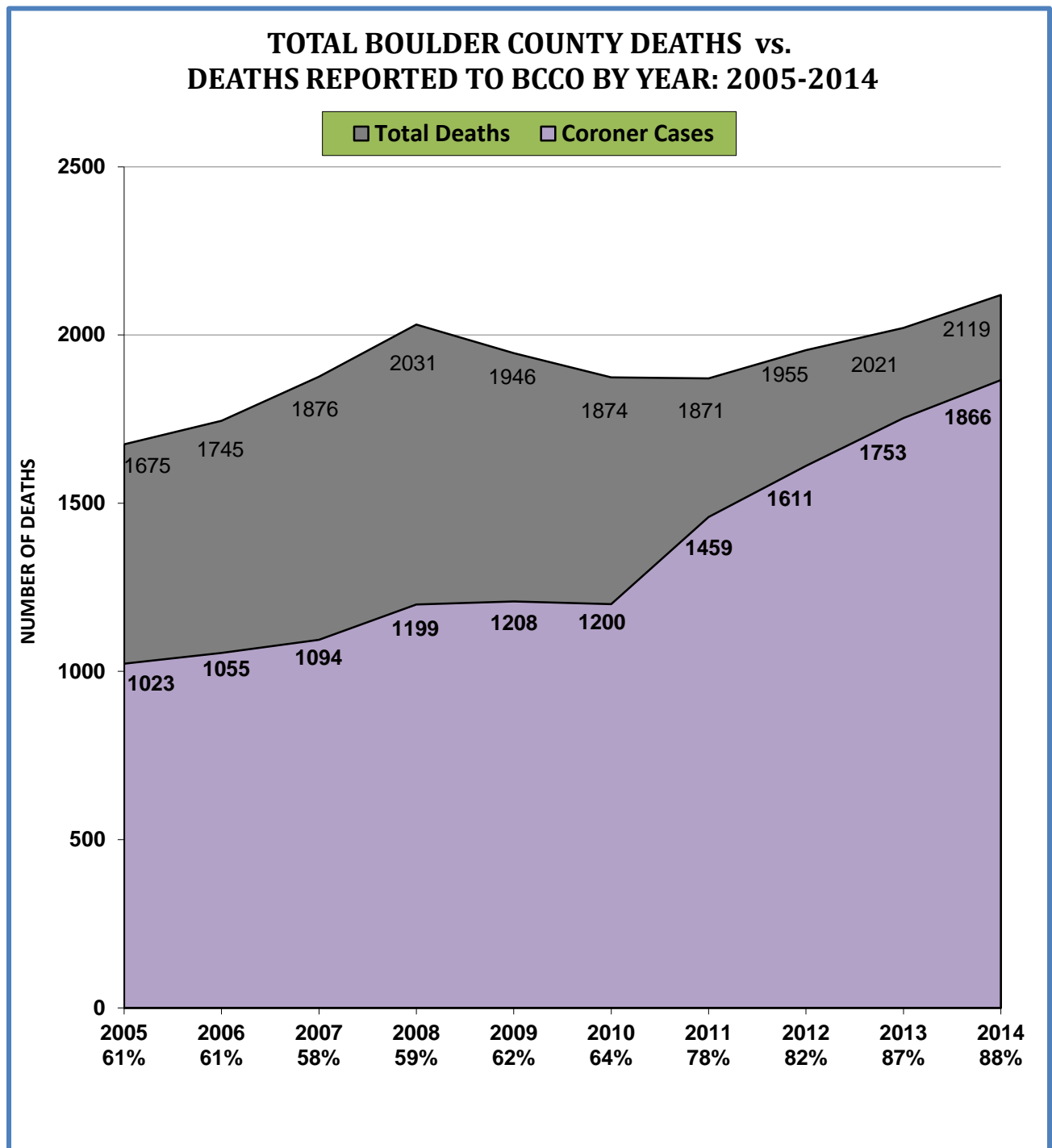
In accordance with Colorado Revised Statute §30-10-606, the following deaths are **reportable** to the Boulder County Coroner's Office:

- If the death is or may be unnatural as a result of external influences, violence or injury;
- Death due to the influence of or the result of intoxication by alcohol, drugs or poison;
- Death as a result of an accident, including at the workplace;
- Death of an infant or child is unexpected or unexplained;
- Death where no physician is in attendance or when, though in attendance, the physician is unable to certify the cause of death;
- Death that occurs within twenty-four hours of admission to a hospital;
- Death from a disease which may be hazardous or contagious or which may constitute a threat to the health of the general public;
- Death occurs from the action of a peace officer or while in custody of law enforcement officials or while incarcerated in a public institution;
- Death was sudden and happened to a person who was in apparent good health;
- When a body is unidentifiable, decomposed, charred or skeletonized;
- Circumstances that the coroner otherwise determines may warrant further inquiry to determine cause and manner of death or further law enforcement investigation.

It should be emphasized that, although a particular death may be "reportable" to the coroner's office; an autopsy may not be necessary depending upon the circumstances.

PERCENTAGES OF BOULDER COUNTY DEATHS REPORTED TO THE CORONER

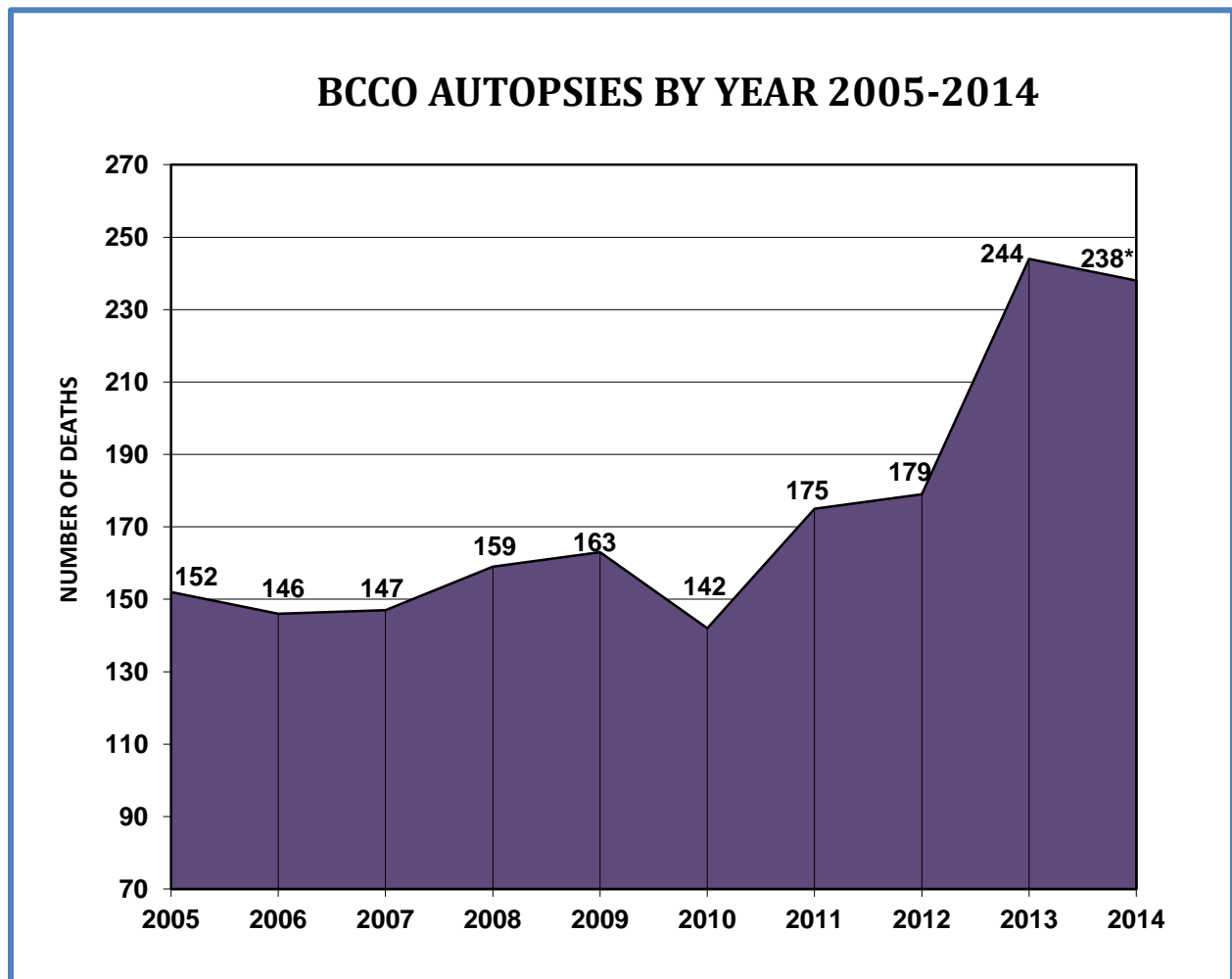
Per the US Census the 2014 estimated population of Boulder County was 313,333. A death certificate is filed with the Boulder County Public Health Department for each death that occurs in Boulder County. The Public Health Department keeps track of the total number of deaths that occur in Boulder County. A portion of the deaths that occur in Boulder County are reported to the Boulder County Coroner's Office. The chart below shows a yearly total of all deaths that occurred in Boulder County and a yearly total of all deaths reported to the Boulder County Coroner.



AUTOPSIES BY YEAR

In approximately thirteen percent of the deaths that were investigated by the Boulder County Coroner's Office in 2014, an autopsy or skeletal postmortem examination was performed to aid in the determination of the cause and manner of death, to document disease, to identify injury patterns, or to recover evidence. Included in almost all autopsies are toxicology tests that may be helpful in determining the cause and manner of death. Toxicology testing and histology review is performed on various specimens collected at autopsy. Several laboratories are used for drug testing. Screening tests include alcohol, illicit drugs, commonly abused prescription and non-prescription drugs, and other substances as needed.

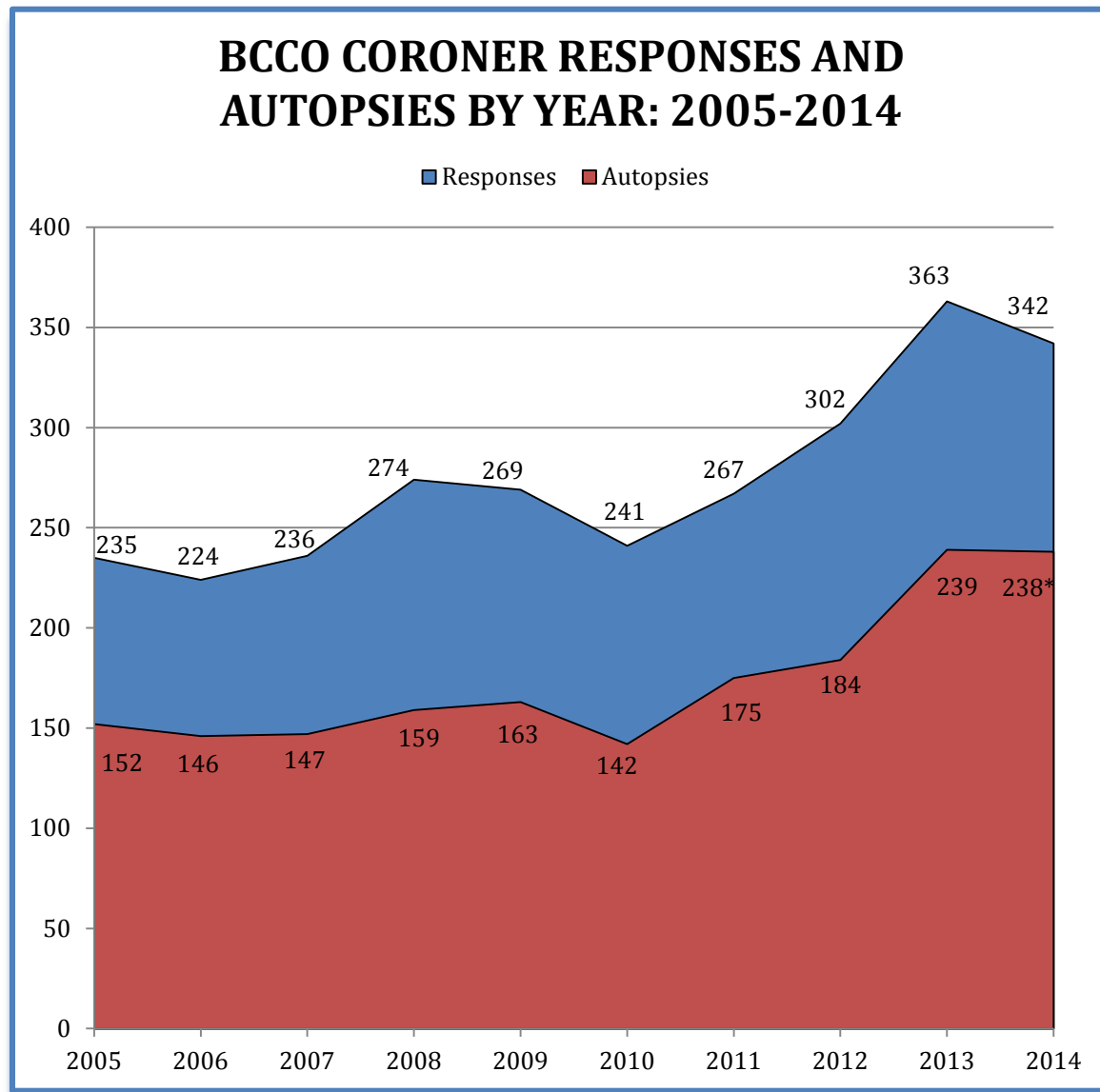
In 2011 House Bill 11-1258 was passed. The bill states that the coroner shall perform forensic autopsies with the most recent version of the "Forensic Autopsy Performance Standards" adopted by the National Association of Medical Examiners (NAME). And that all forensic autopsies must be performed by a board-certified forensic pathologist.



Note: *The Boulder County Coroner's Office performed 238 autopsies in 2014; this included two hundred thirty-seven 2014 cases and one 2013 case.

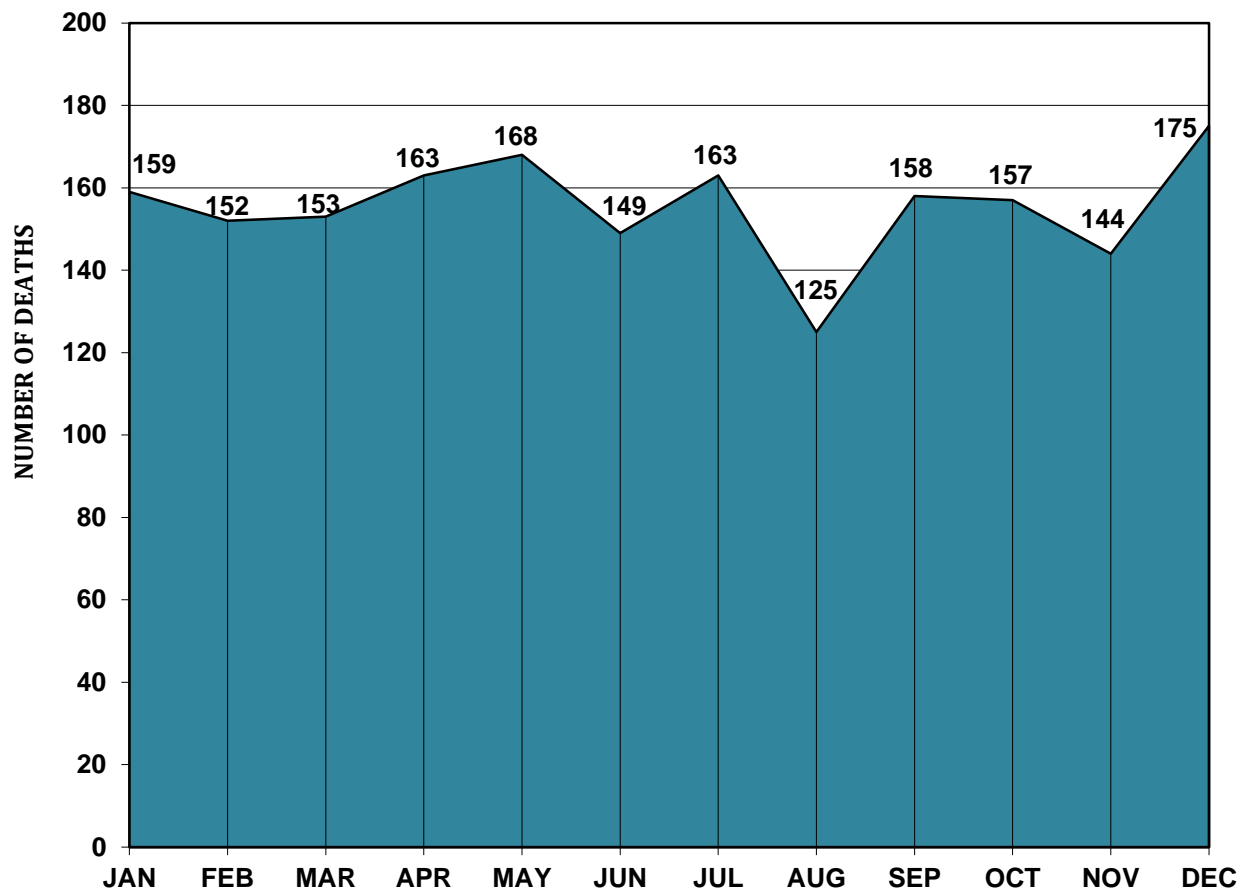
CORONER RESPONSE AND AUTOPSY TOTALS

The Boulder County Coroner's Office makes a physical response to a low percentage of its total case load and performs an autopsy on an even lower percentage of its total case load. The chart below shows the annual trend lines for both the responses and the autopsies.



Note: * There were 237 cases in 2014 that required autopsies. One autopsy performed in 2014 was a 2013 case, for a total of 238 autopsies performed in 2014.

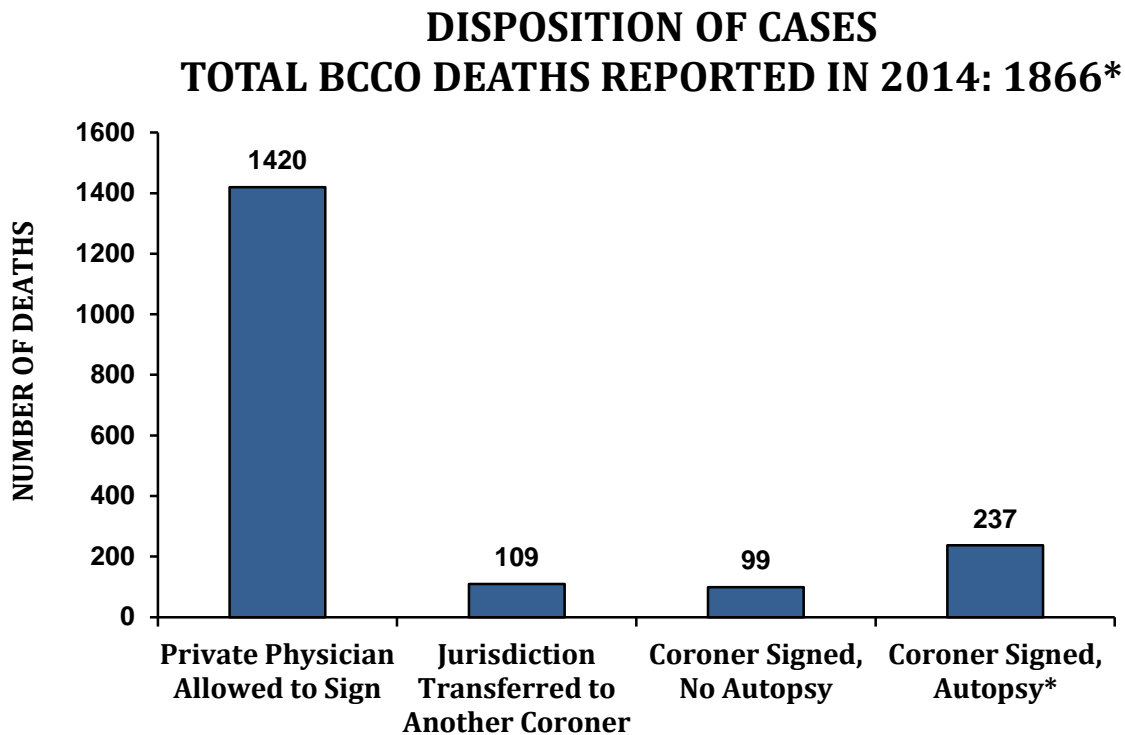
CASES BY MONTH

CASES REPORTED TO BCCO BY MONTH - 2014
TOTAL CASES REPORTED IN 2014: 1866*

Note: *The total number of cases reported includes 109 cases that were transferred to other coroners. See **Transfer of Jurisdiction** section of this report for further explanation.

DISPOSITION OF CASES

Deaths that fall under the jurisdiction of the coroner are handled in one of four ways. Most commonly, if the death is due to natural disease and if a private physician who has treated the decedent is able to certify the cause of death, the coroner may allow the private physician to sign the death certificate. Or the coroner may assume jurisdiction over the death and conduct an investigation and an autopsy to determine cause and manner of death and then issue a death certificate. Or the coroner may assume jurisdiction of a death and conduct an investigation, but not perform an autopsy. Or, even though a death may have occurred in the county, a “transfer of jurisdiction” may occur to the coroner of the county where the initiating event causing death occurred or where the decedent was transported (i.e. by ambulance) from prior to death. The transfer of jurisdiction is allowed according to Colorado Revised Statute §30.10.606.



Note: *While the total number of cases was 1866 for 2014, there was one case in which a death certificate was not signed as the partial remains are yet to be identified.

TRANSFER OF JURISDICTION

Occasionally deaths that occur in Boulder County are due to an “initiating event” that occurred in another county. For example, an individual may die in a hospital from injuries that he/she sustained in an accident that occurred in another county, or an individual may collapse at his/her residence (in another county), be transported to a hospital in Boulder County, and subsequently die in that hospital. In these cases, the Boulder County Coroner will transfer jurisdiction (subsequent investigation and certification) to the coroner of the county in which the “initiating event” occurred.

In 2014, the jurisdictions of 109 cases were transferred to other coroners in surrounding counties. Sixty-seven cases were natural deaths, five were traffic accidents, twenty-nine were non-traffic accidents, six were suicides, one was undetermined, and one was a homicide. Fifty-six of the cases were transferred to Adams/Broomfield County, thirty-one were transferred to Weld County, eighteen were transferred to Jefferson County, one was transferred to Larimer County, one was transferred to Denver County, and one was transferred to Park County.

Thirty-six of the transferred cases were deaths that occurred in an emergency department. Thirty-two of them occurred at Exempla Good Samaritan Medical Center, three occurred at Avista Adventist Hospital and one occurred at Longmont United Hospital.

In 68% (74 of the 109) of the cases that were transferred to other coroners, the decedents were transported to Exempla Good Samaritan Medical Center from areas outside of Boulder County (this includes the 31 EGSMC ED deaths).

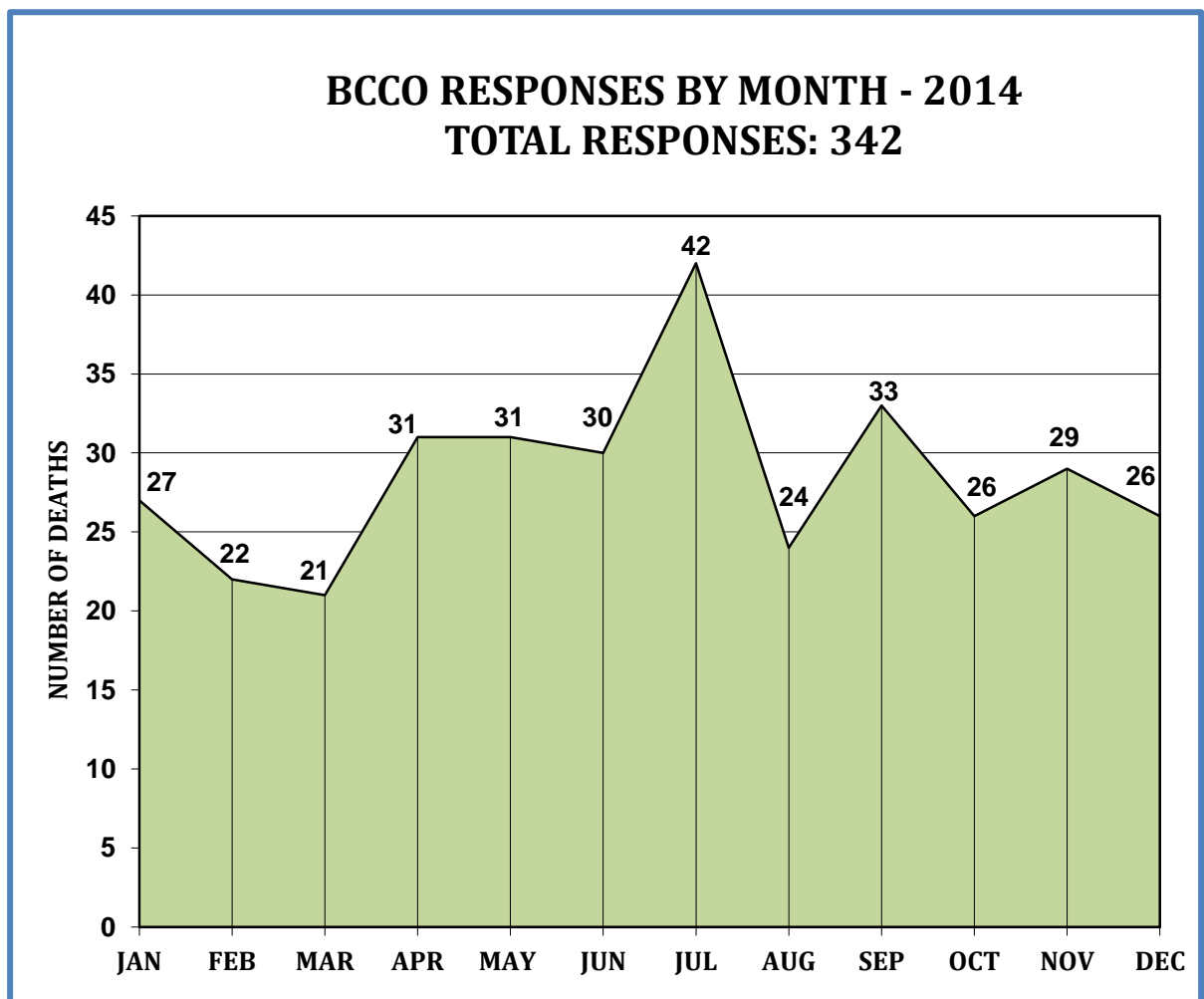
For statistical purposes, in the sections to follow, transferred cases will not be counted among the deaths investigated by Boulder County, unless otherwise noted.

CORONER RESPONSES BY MONTH

The Boulder County Coroner's Office is called to action by either receiving a phone report of a death or by receiving a notification and response request from law enforcement. When a death is reported to the office by phone it is typically being reported by a hospice agency, a care center or a hospital. The coroner's office will make a determination if a response is necessary; if not a phone report is taken and the office may follow up with attaining additional medical records and conducting further interviews as needed. A response is made by the coroner's office to the care center or hospital if further information is needed at the time of death.

Most responses made by the coroner's office are to death scenes where law enforcement has notified and requested the coroner's office. Law enforcement has jurisdiction over the scene, while the coroner's office has jurisdiction over the body, therefore both agencies work together to accomplish their individual responsibilities. The coroner's office is responsible for determining manner and cause of death, identifying the decedent and notifying the next of kin. Law enforcement's responsibility is to determine and document any crime that may have occurred or the lack thereof.

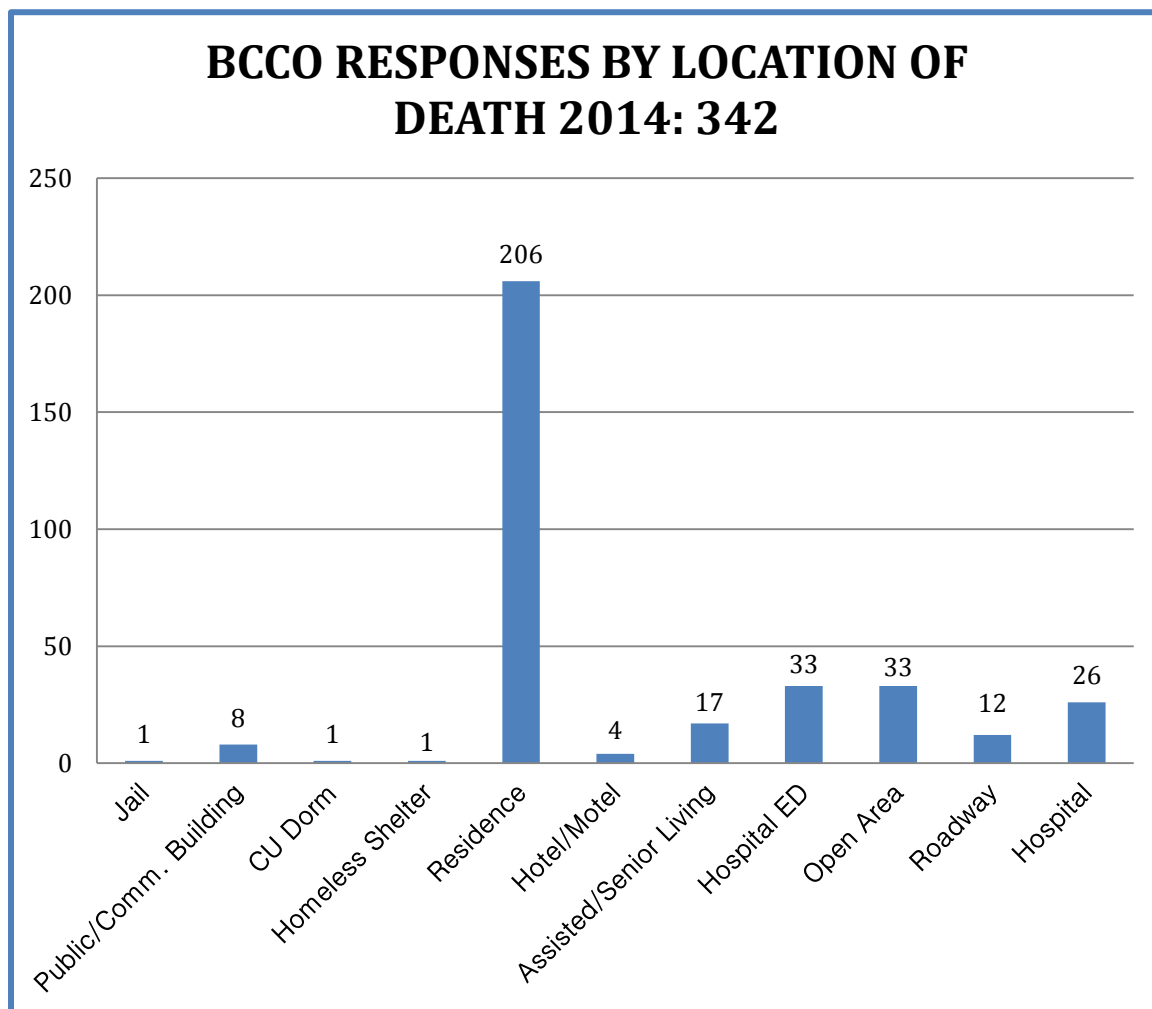
In 2014, 342 scene responses were made which was 18% of all of the deaths reported to the Boulder County Coroner's Office.



CORONER REPONSES BY LOCATION OF DEATH

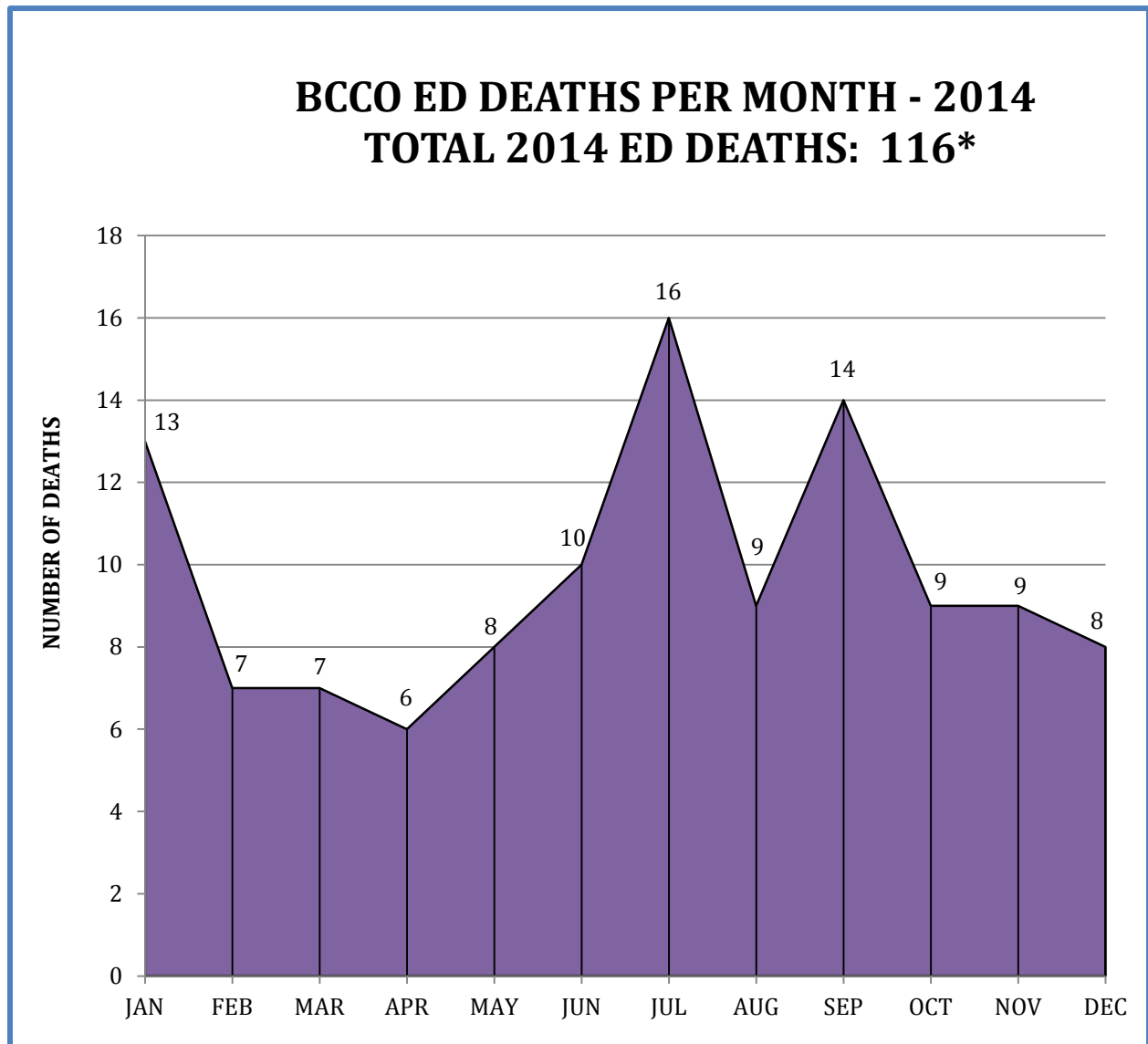


BCCO all-terrain response vehicle, equipped for mountain responses.



EMERGENCY DEPARTMENT CALLS BY MONTH

Deaths that occur in an emergency department are required to be reported to the coroner's office. Hospitals in Boulder County include Boulder Community Hospital, Boulder Community Hospital Foothills, Longmont United Hospital, Exempla Good Samaritan Medical Center, and Avista Adventist Hospital.

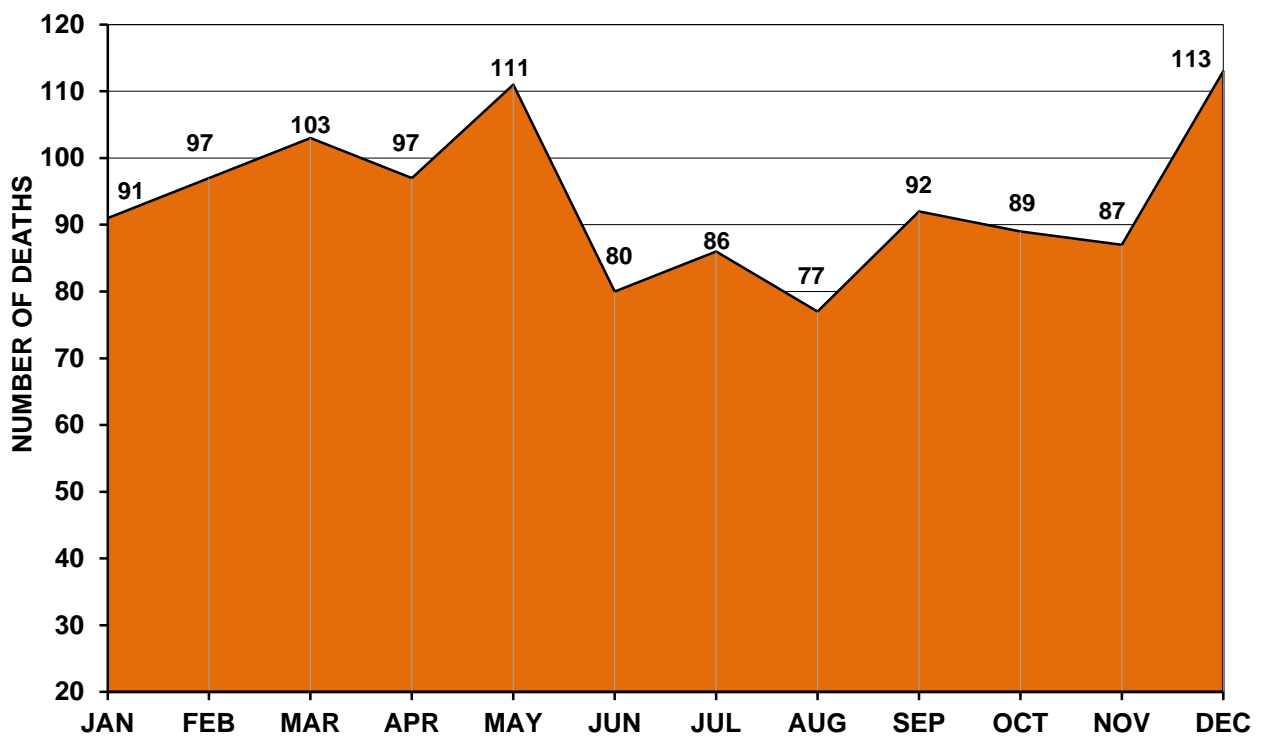


Note: *The total number of cases reported includes 36 cases that were transferred to other coroners. See **Transfer of Jurisdiction** of this report for further explanation.

HOSPICE CASES BY MONTH

Deaths occurring under hospice care in Boulder County are reported to the Boulder County Coroner's Office. There are several hospice organizations operating throughout Boulder County. Of the 1139 hospice cases reported to the Boulder County Coroner's Office 1087 (95.4%) were natural deaths, 50 (4.4%) were accidental deaths, one (<0.1%) was undetermined and one (<0.1%) was a suicide. Of the 1139 hospice cases, two of them included an autopsy (one for unknown trauma sustained prior to hospice placement and the other due to signs of suicide).

BCCO HOSPICE DEATHS BY MONTH - 2014 TOTAL 2014 HOSPICE DEATHS: 1123*



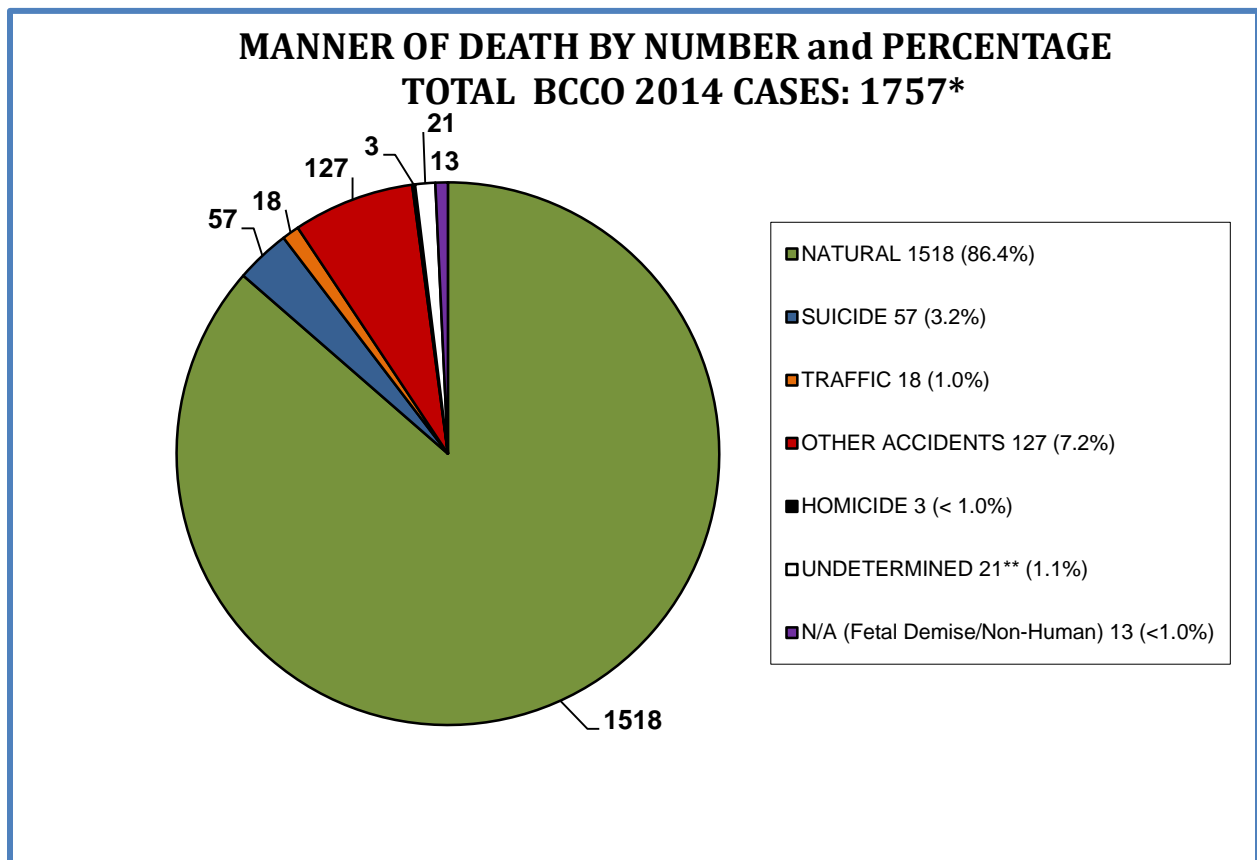
Note: *This total excludes the 16 hospice cases that were transferred to other coroners.

MANNER OF DEATH

One of the main responsibilities of the coroner's office is to determine the manner of death. The manner of death is a classification of death based on the circumstances surrounding the cause of death and how that cause came to be. There are five manners of death: Natural, Suicide, Accident, Homicide and Undetermined. The manner of death is one of the items that must be reported on the death certificate. The manner of death was added to the US Standard Certificate of Death in 1910; it was added by public health officials as a way to code and classify cause of death information for statistical purposes. It should be noted that the medical-legal definition of Homicide means death caused by another, and is not based on intent. A ruling of Homicide does not indicate or imply criminal intent.¹

MANNER OF DEATH BY NUMBER AND PERCENTAGE

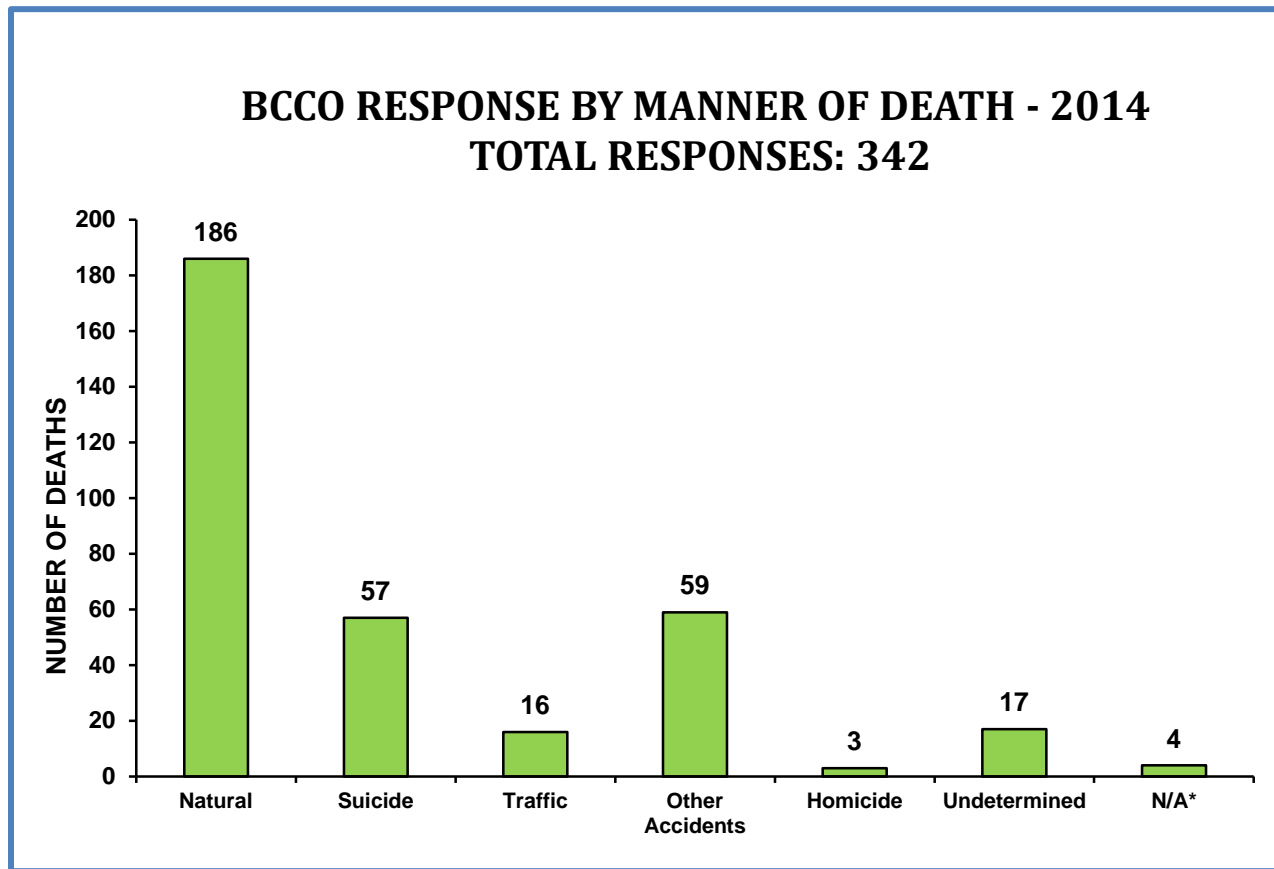
A large majority of the cases investigated by any medical examiner or coroner's office are natural deaths. In Boulder County that figure was 1518 cases, or 86.4% in 2014. Included within these natural deaths were 1080 hospice cases.



Note: *The 109 cases transferred to other coroners are not included in this total.

**The total number of Undetermined cases includes one case in which a death certificate has not been signed since the partial remains have yet to be identified.

Note: Statistical information may not coincide with information available from the Colorado Health Department. The State Health Department tracks death statistics by the county of residence, not by the county where the injury or death occurred.



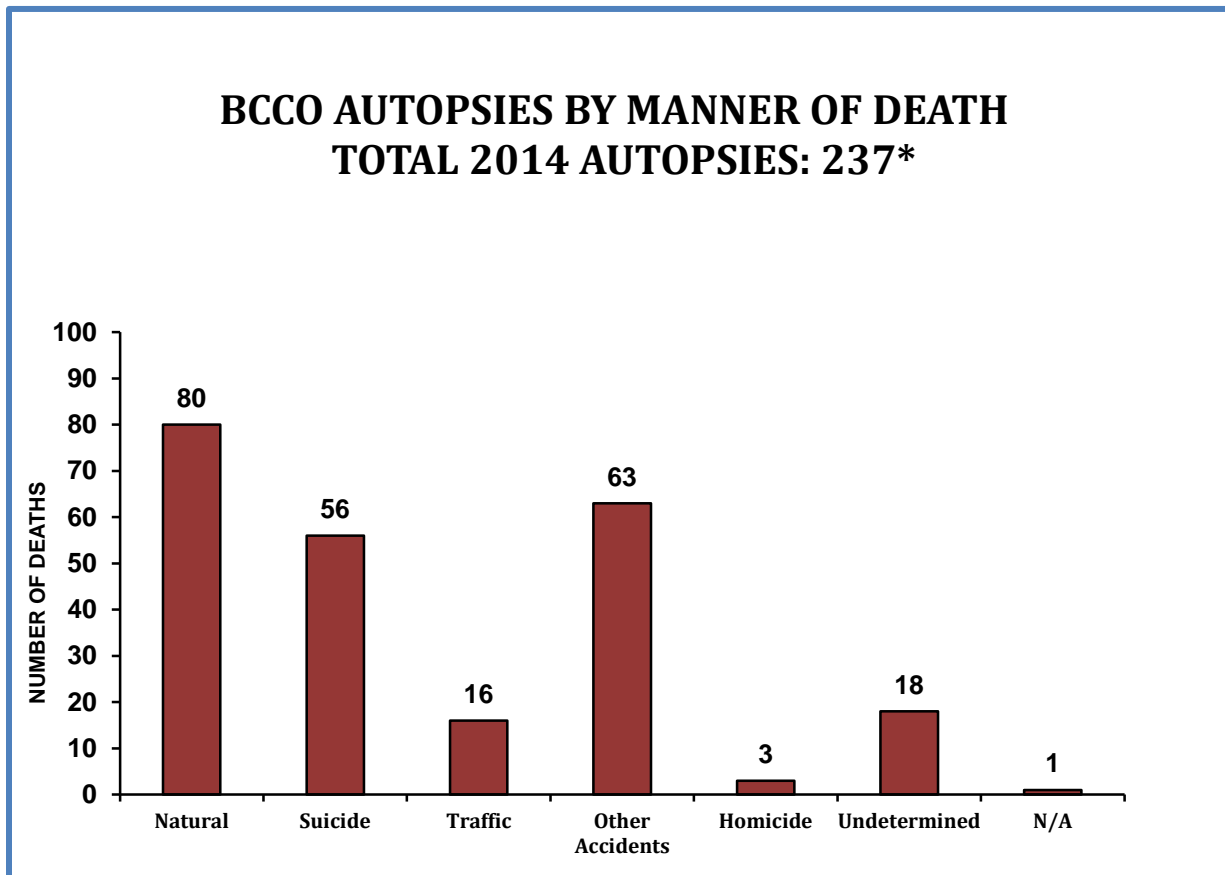
Note: The apparent absence of a scene investigation in some suicides, motor vehicle, and other accident cases may be due to extended survival of the victim in a hospital, or because the victim was transported by emergency personnel to a hospital outside the county and subsequently died away from the scene.

* The N/A manner of death includes 3 fetal demises cases and 1 case where the partial remains have yet to be identified.

For statistical purposes accidental deaths due to traffic accidents will be separated from accidental deaths due to other causes.

AUTOPSIES BY MANNER OF DEATH

The Coroner weighs many factors in order to determine whether an autopsy should be performed. Autopsies are performed in all homicides, most infant deaths, most deaths of individuals without an established medical history, deaths involving possible criminal action, most motor vehicle accident deaths, and most suicides.

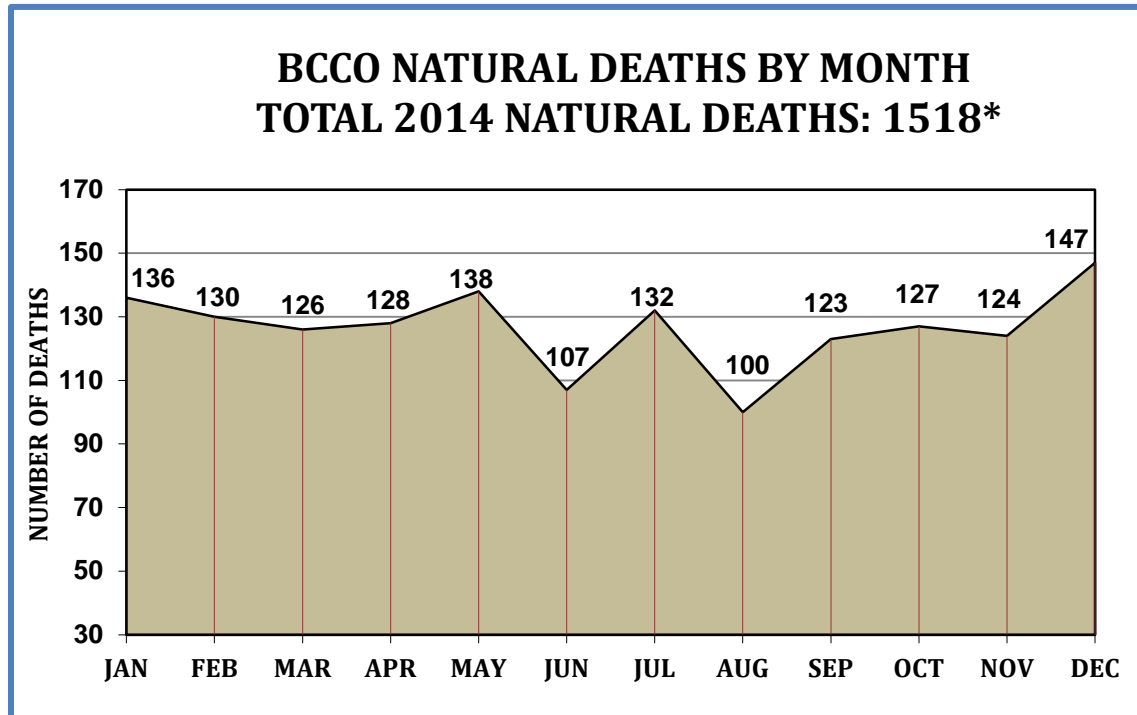


Note: *All cases in 2014 that required an autopsy were completed in 2014, this chart does not include the one 2013 case where the autopsy was performed in 2014.

NATURAL DEATHS

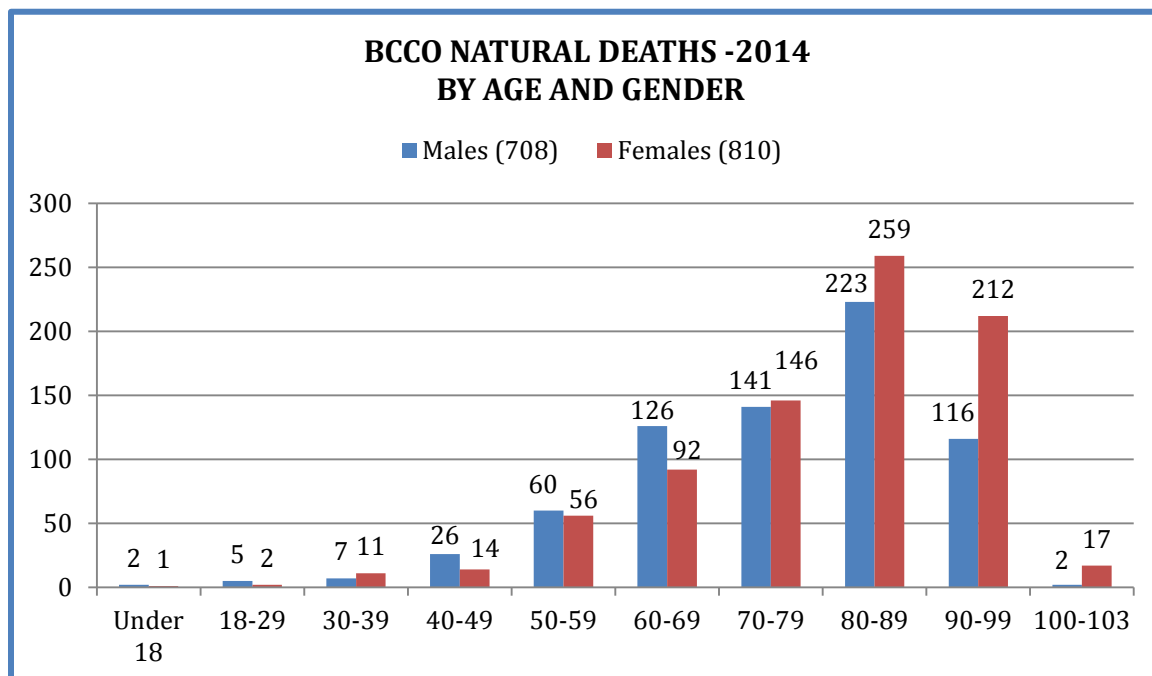
NATURAL DEATHS BY MONTH

Natural deaths comprise the majority of all deaths nationwide and holds true for the cases handled by the Boulder County Coroner's Office.



Note: *This total does not include the 66 natural deaths transferred to other coroners.

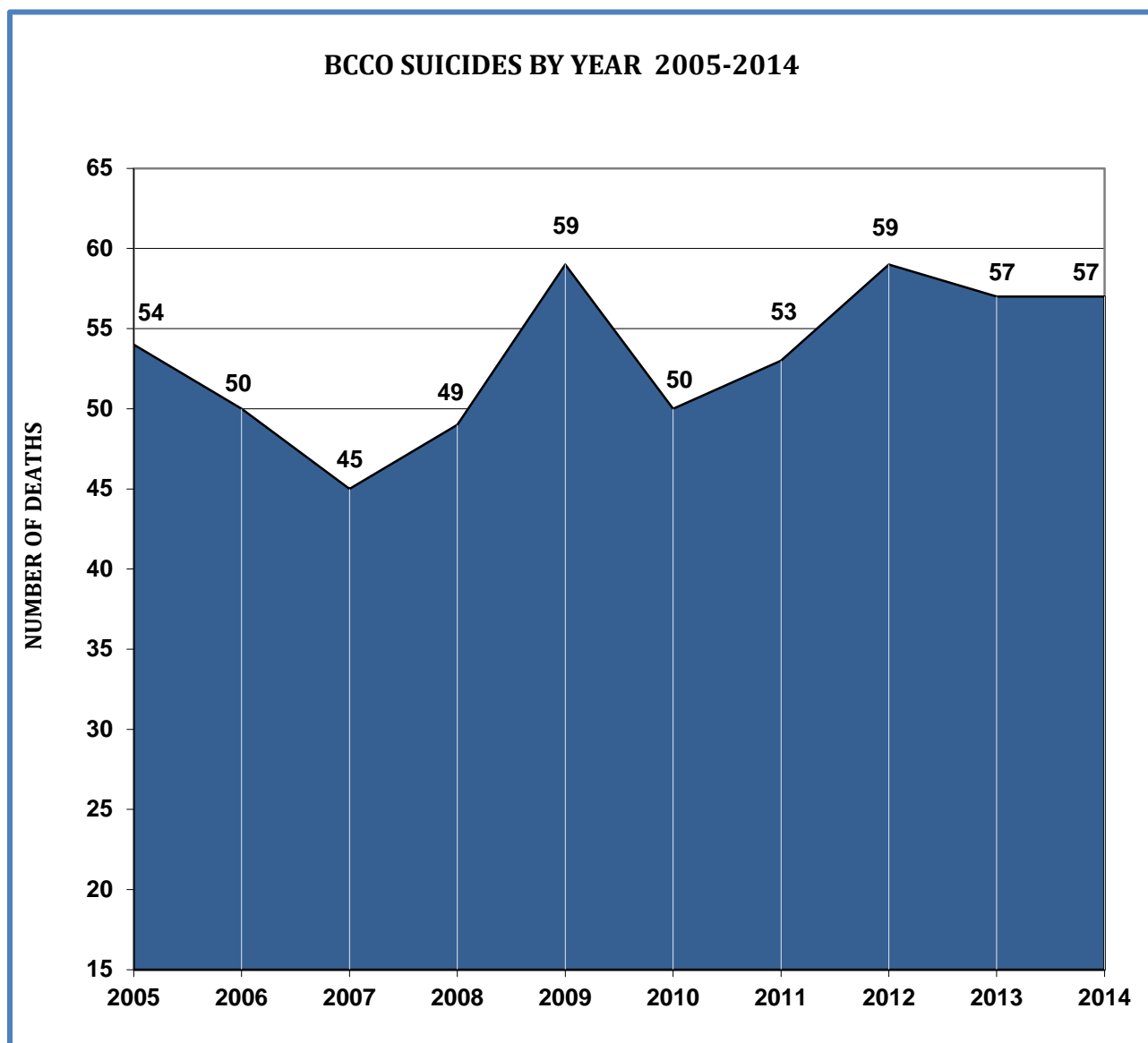
NATURAL DEATHS BY AGE AND GENDER



SUICIDES

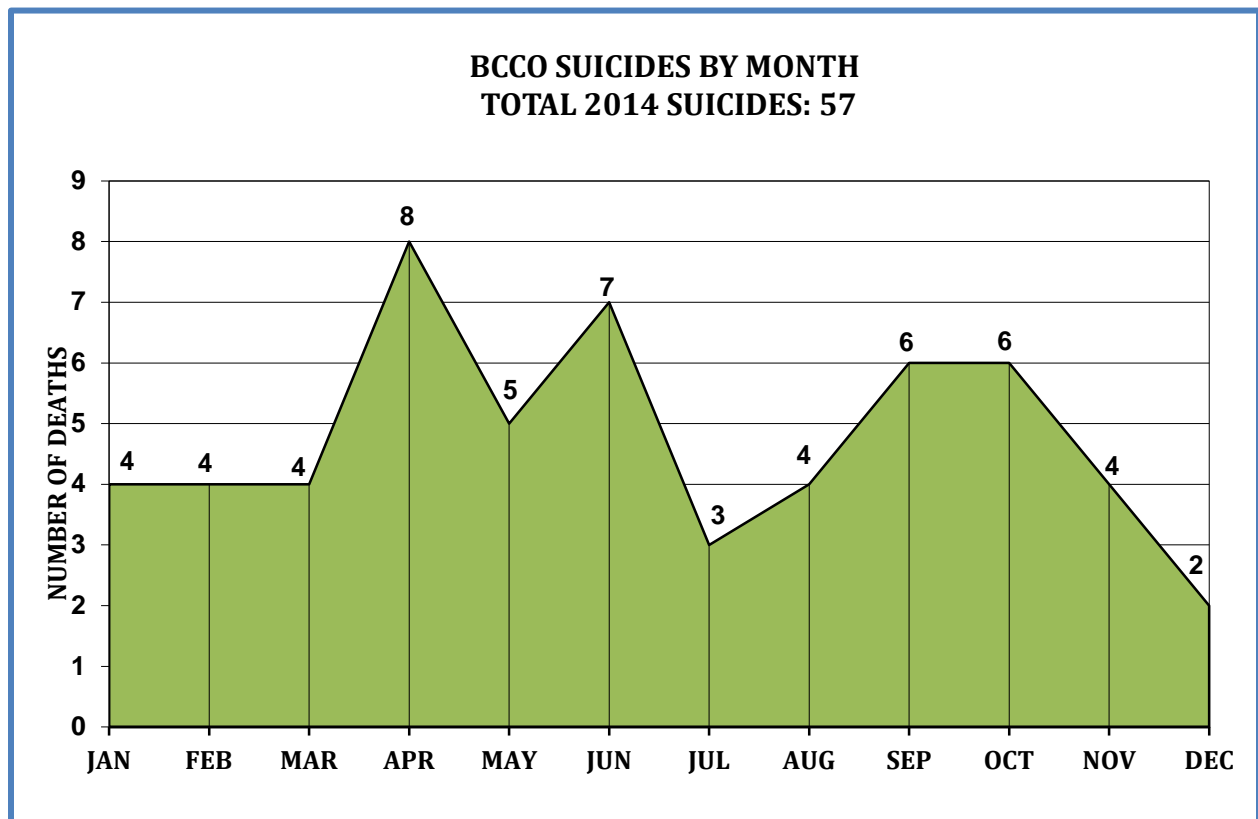
Suicide is defined as the intentional act of killing oneself. Nationally, men are three to five times more likely to commit suicide than women, but women attempt suicide more frequently than men. The most common method of committing suicide is with firearms, followed by hanging, suffocation, and ingestion of poisons.² In 2014 in Boulder County, the most common method used was a firearm, followed by hanging and then by prescription drugs.

SUICIDES BY YEAR



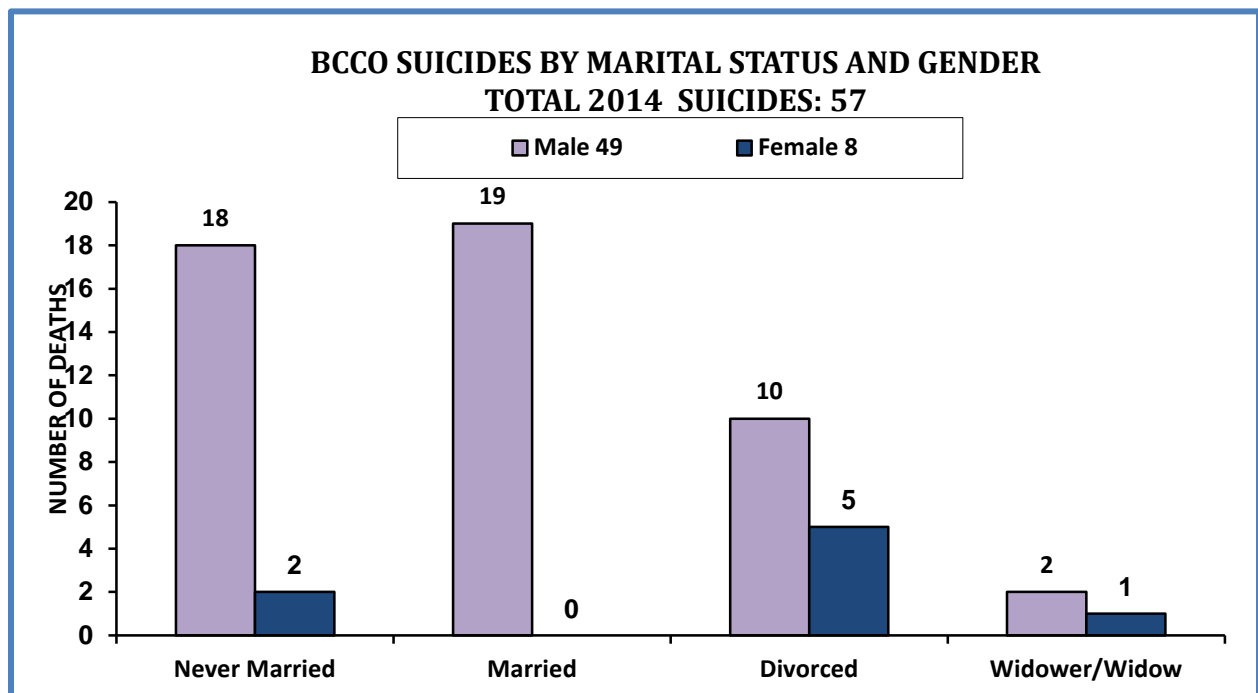
Note: There were a total of 63 suicides reported to the Boulder County Coroner's Office in 2014. The Boulder County Coroner's Office investigated 57 of those cases and transferred jurisdiction of six cases to other coroners.

SUICIDES BY MONTH

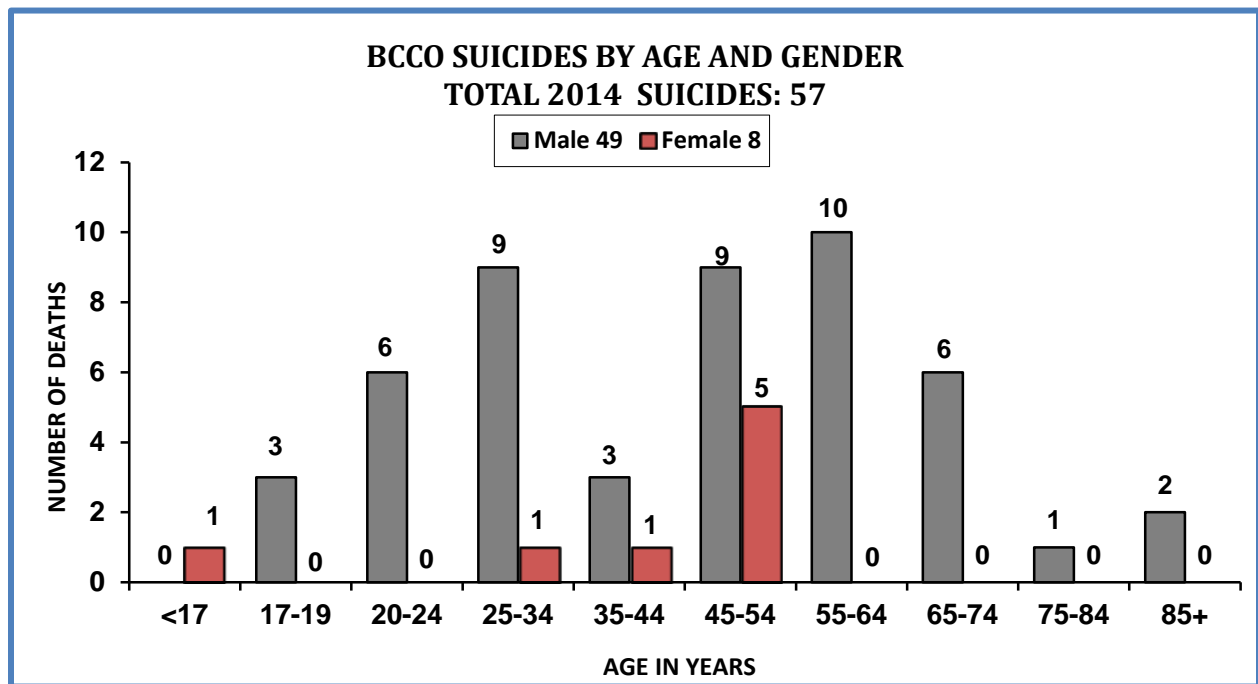


Note: Ten of the suicides were non Boulder County residents; one of the 10 was a transient.

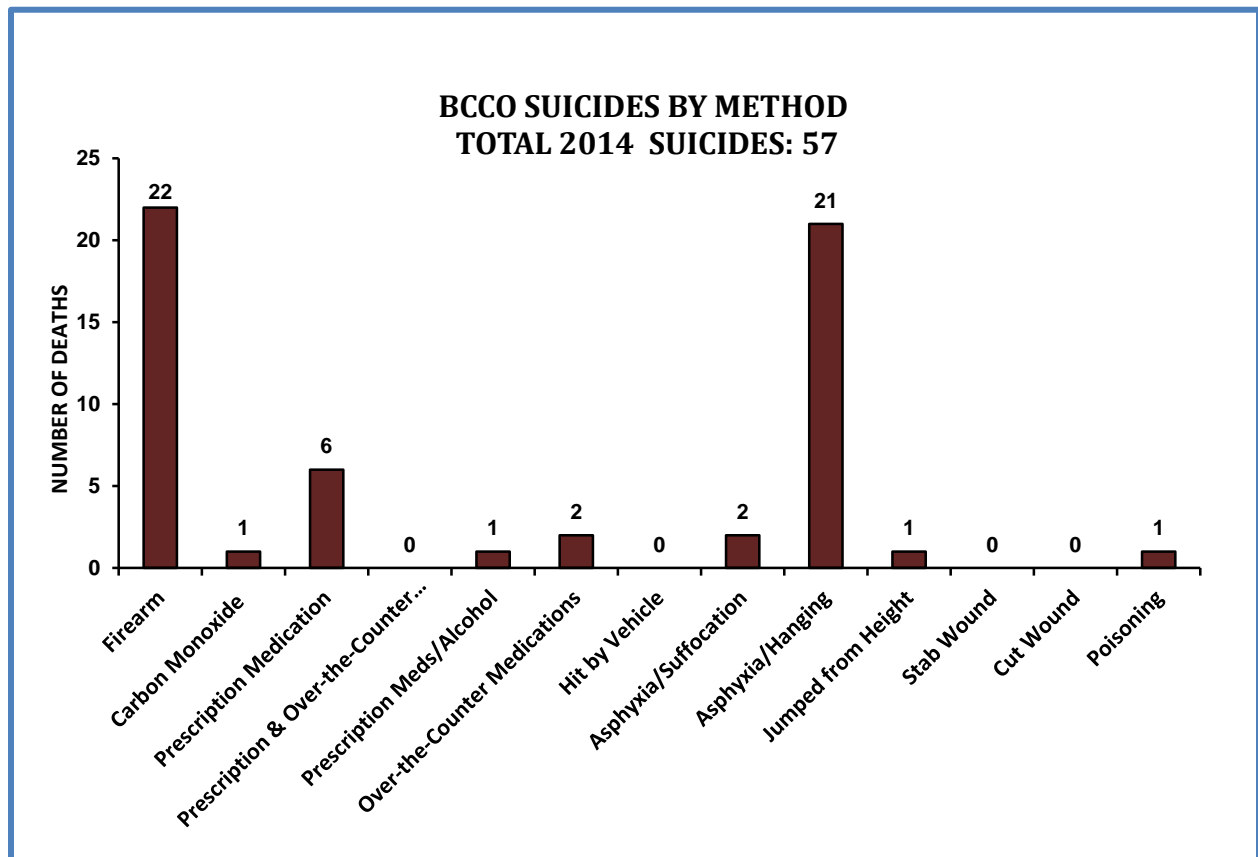
SUICIDES BY MARITAL STATUS AND GENDER

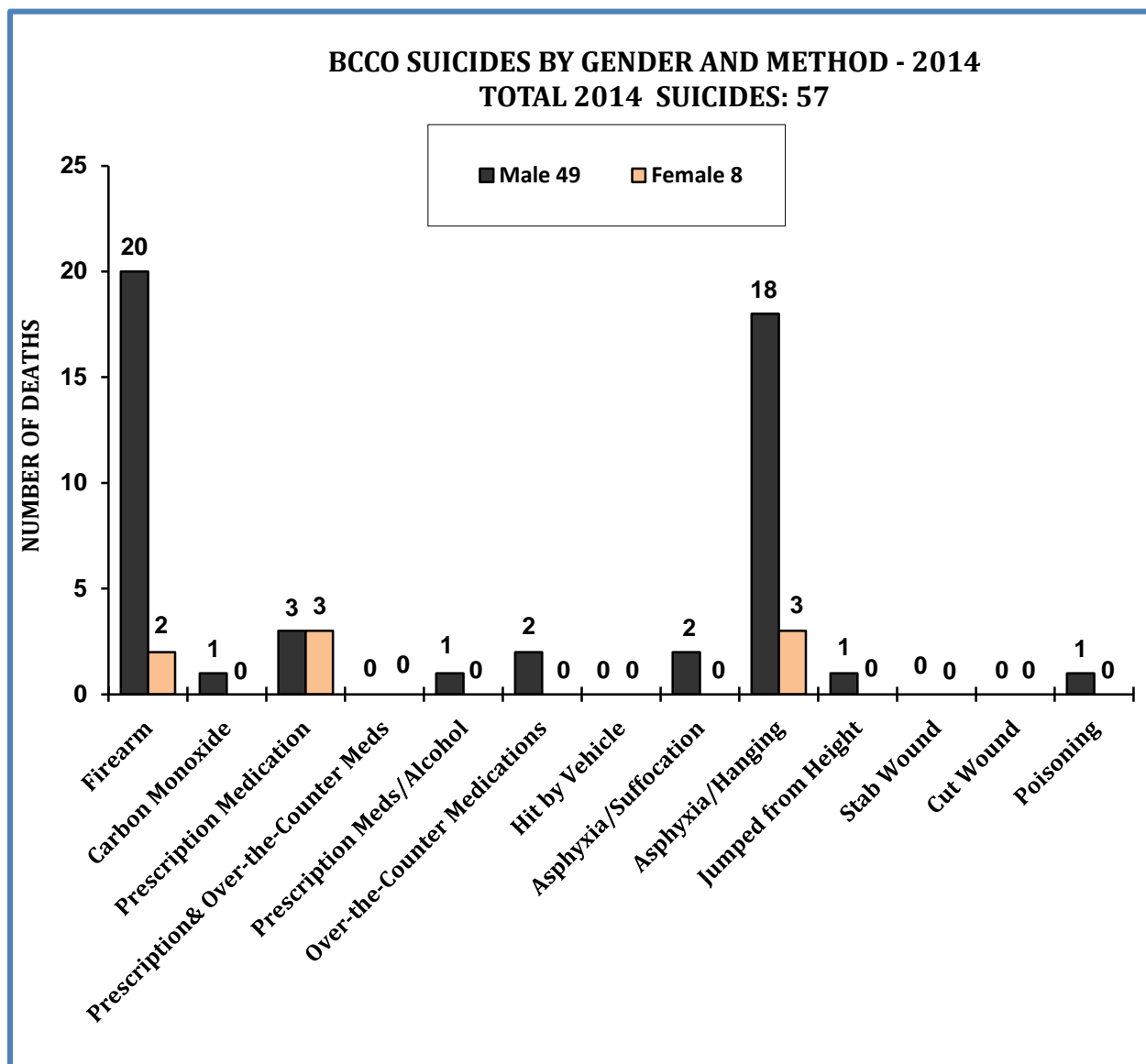


SUICIDES BY AGE AND GENDER



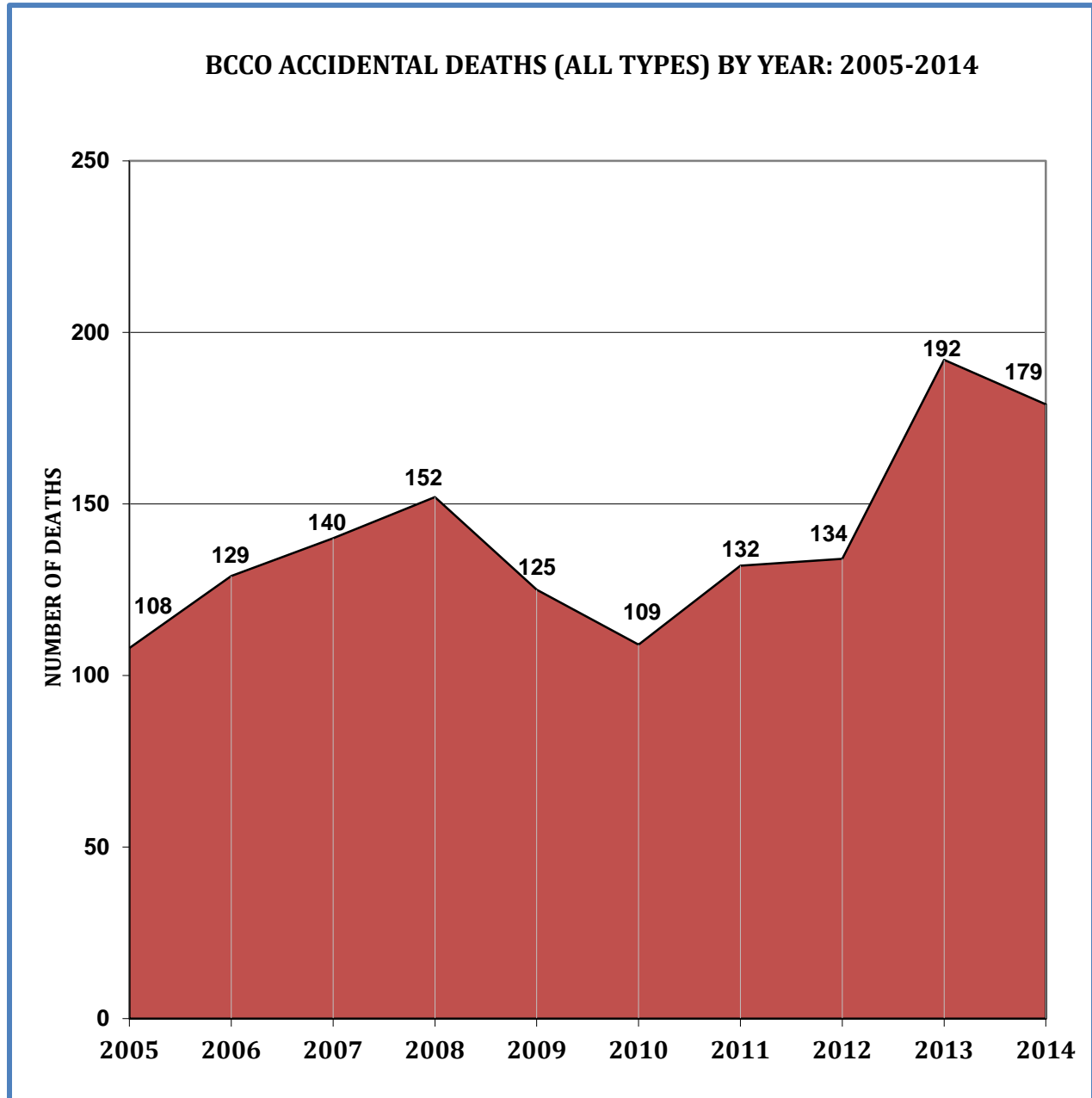
SUICIDES BY METHOD





ACCIDENTAL DEATHS

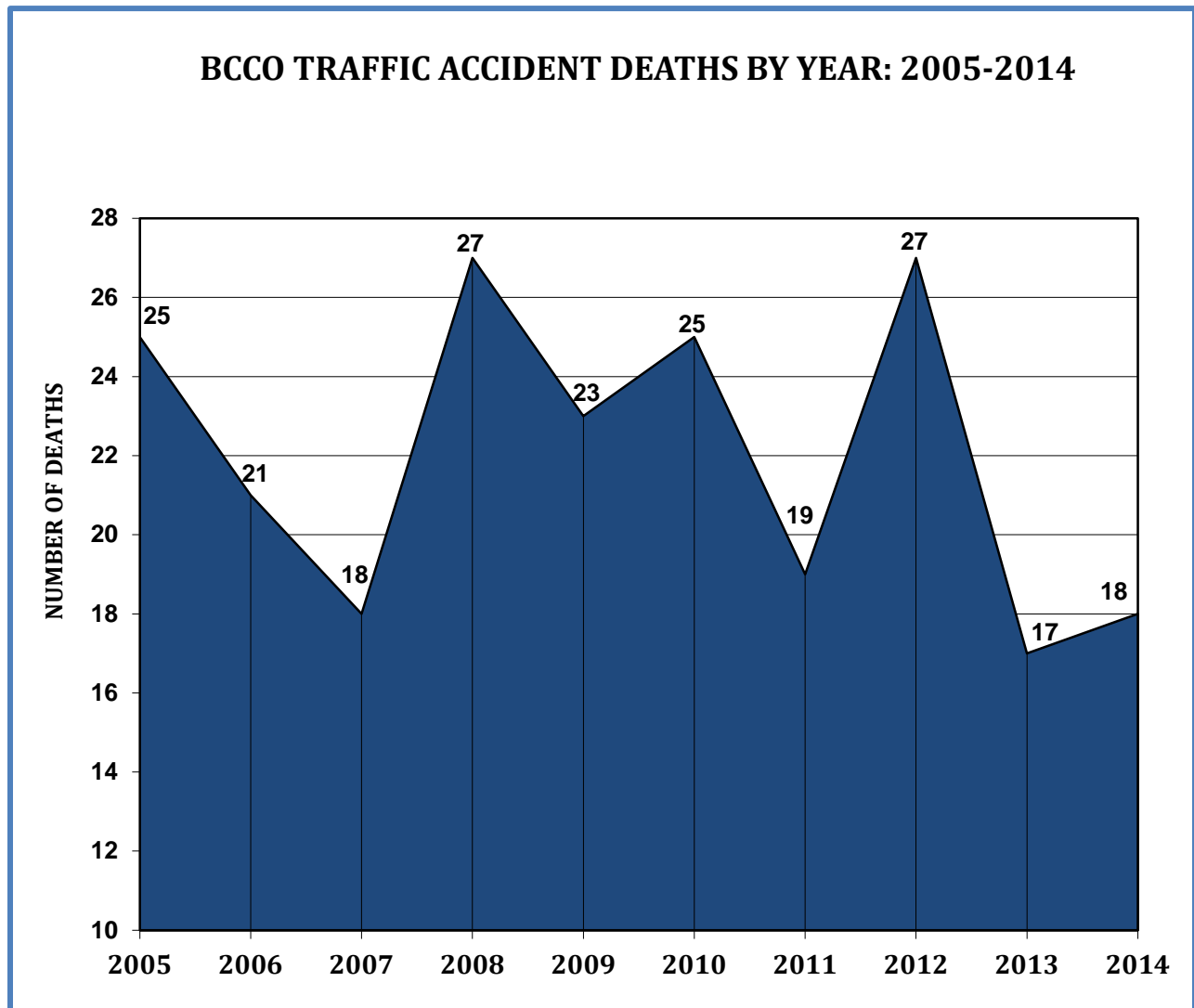
ACCIDENTAL DEATHS BY YEAR, ALL TYPES



Note: In 2014, a total of 179 accidental deaths were reported to the Boulder County Coroner, thirty-four of those cases were transferred to other coroners.

TRAFFIC INCIDENT DEATHS BY YEAR

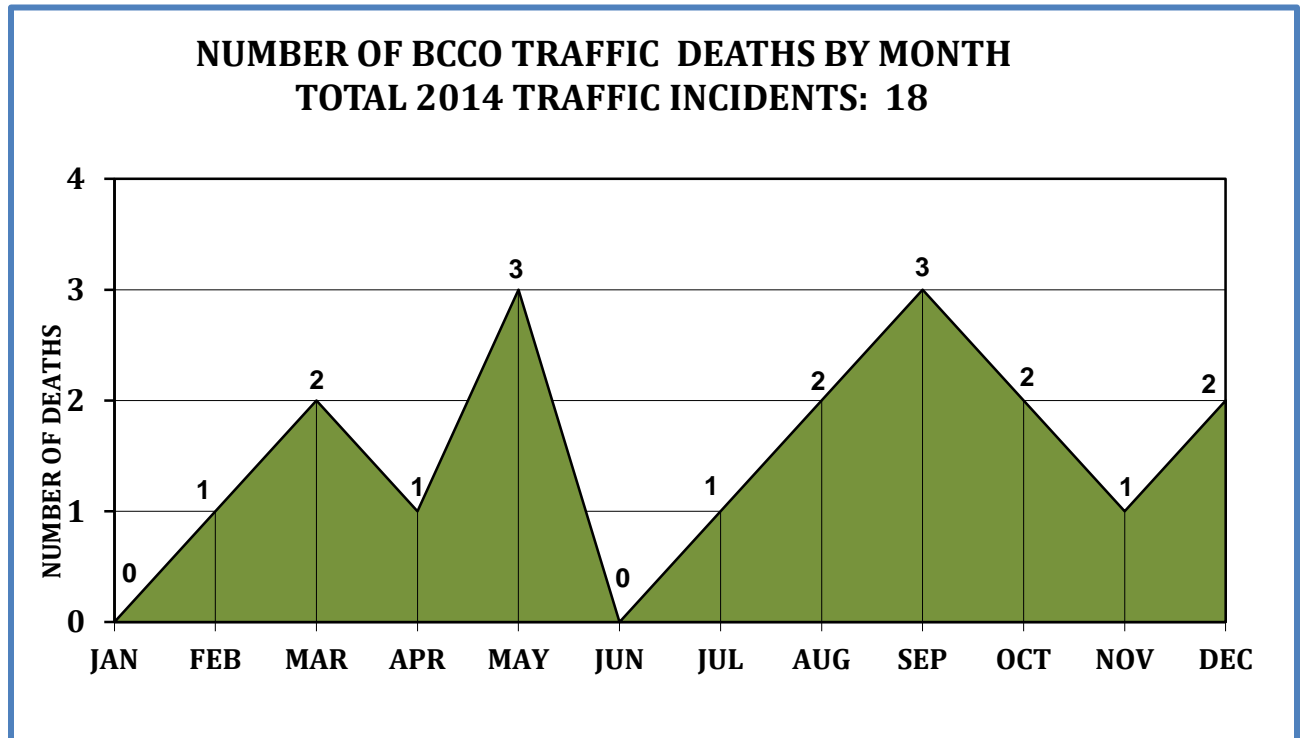
For the purpose of this report, deaths of occupants of a motor vehicle, motorcycle, bicycle, or all-terrain vehicle, and vehicle-pedestrian accidents, are considered to be traffic accident deaths.



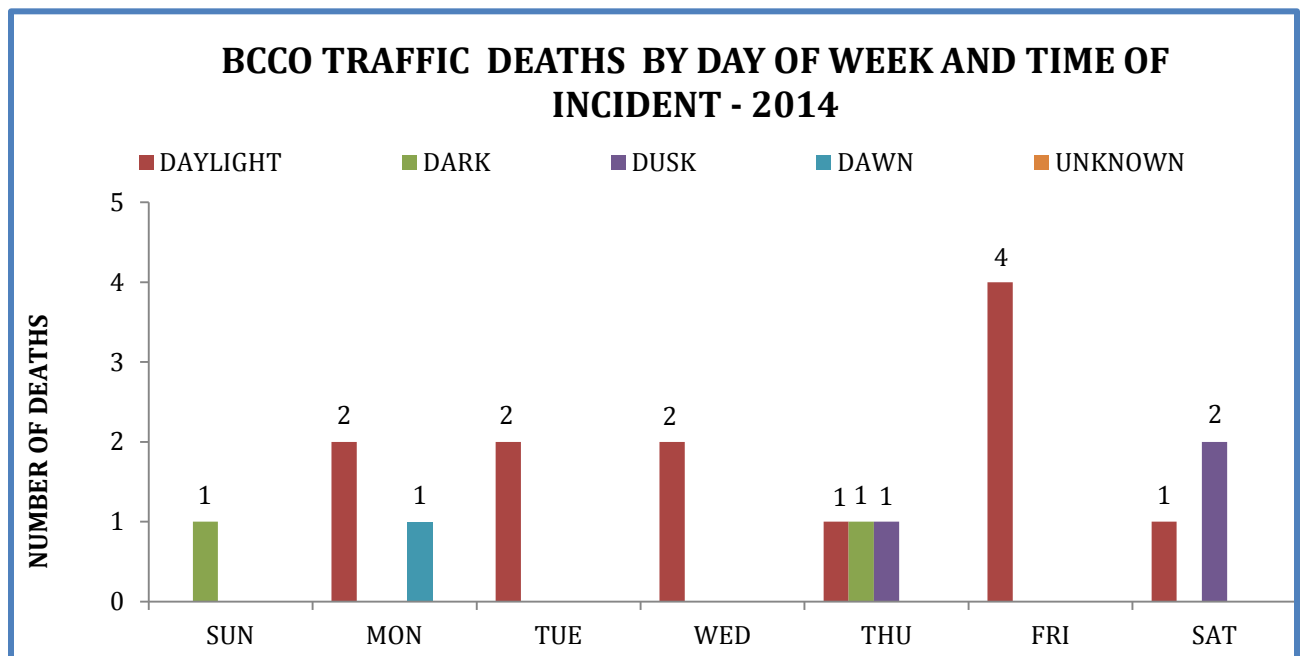
The Boulder County Coroner's Office investigated eighteen deaths resulting from traffic incidents in 2014, all of these incidents occurred in Boulder County. Of the eighteen cases, thirteen of the victims were male and five were female. Their ages ranged from thirteen to eighty-six years of age. Eleven people died due to injuries or complications from injuries sustained in motor vehicle accidents (including automobiles, pickup trucks, SUVs and vans), five people died in motorcycle accidents, one person died as a pedestrian struck by a motor vehicle, and one person died after being struck by a semi-truck at a job site; there were no deaths involving bicycles. Among the eighteen traffic fatalities, eleven were drivers and five were passengers. Three drivers and four passengers were wearing seatbelts. Of the motorcyclists two were wearing a helmet and three were not.

Note: There were a total of 23 traffic incident deaths reported to the Boulder County Coroner's Office in 2014. The Boulder County Coroner's Office investigated 18 of these cases; the other five cases were transferred to another coroner's jurisdiction.

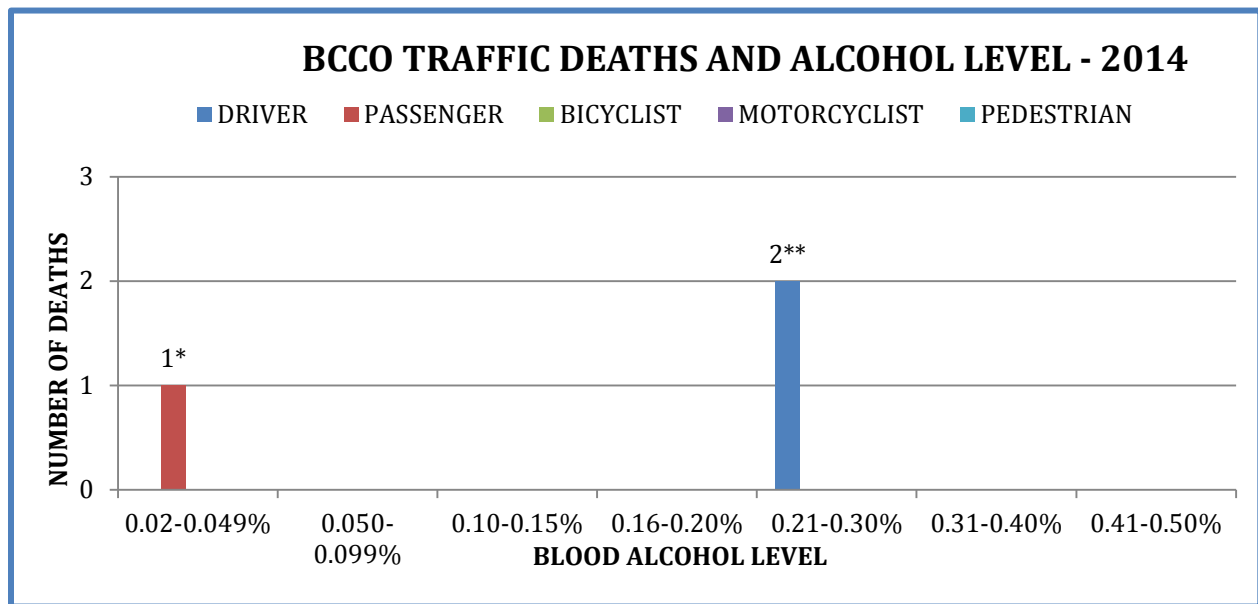
TRAFFIC DEATHS BY MONTH



TRAFFIC DEATHS BY DAY OF WEEK AND TIME OF INCIDENT



Note: The graph displays the information base on the time of incident, not the death.



In Colorado in 2014, a driver is presumed to be Driving While Ability Impaired (DWAI) when a blood alcohol or breath concentration (BAC) is between .050% and .079%. Prior to July 1, 2004 the blood alcohol concentration threshold was .10% to be considered Driving Under the Influence (DUI). As of July 1, 2004, a driver is presumed to be Driving Under the Influence when the BAC is 0.080% or higher. The legal drinking age is 21.

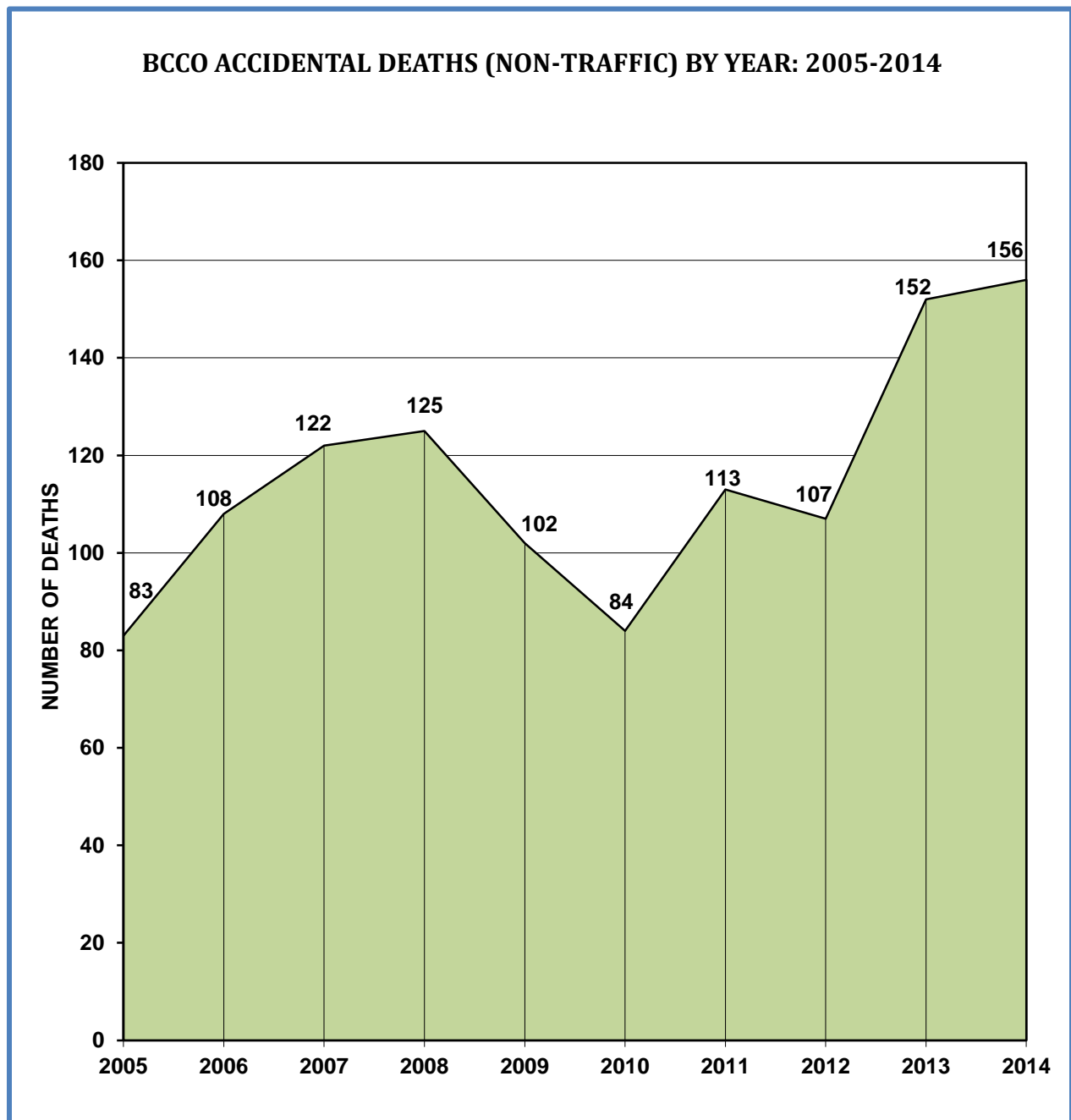
Notes:

*This decedent also tested positive for THC.

**One of these decedents also tested positive for THC.

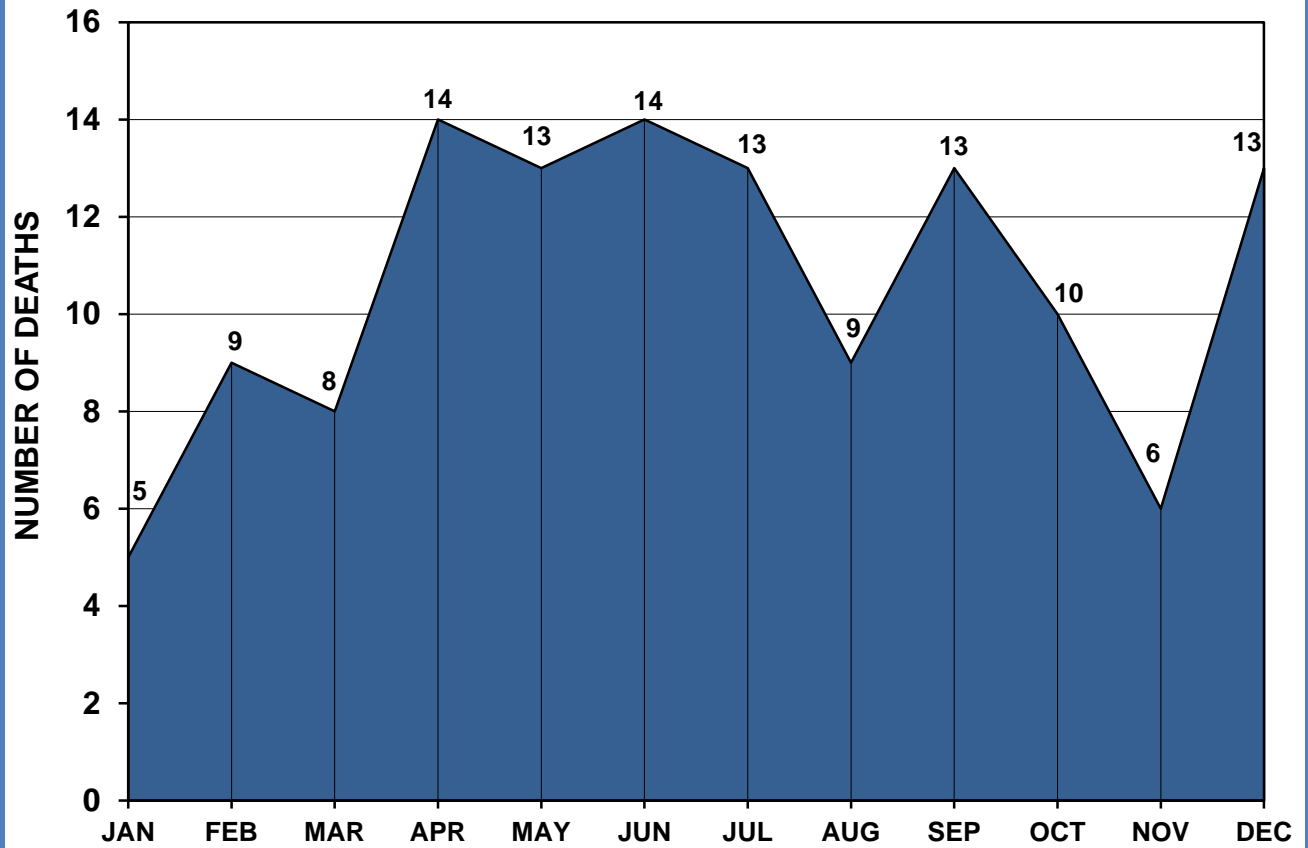
There were 4 cases in which the driver did not test positive for Alcohol but did test positive for THC, 2 of the 4 drivers were motorcyclists.

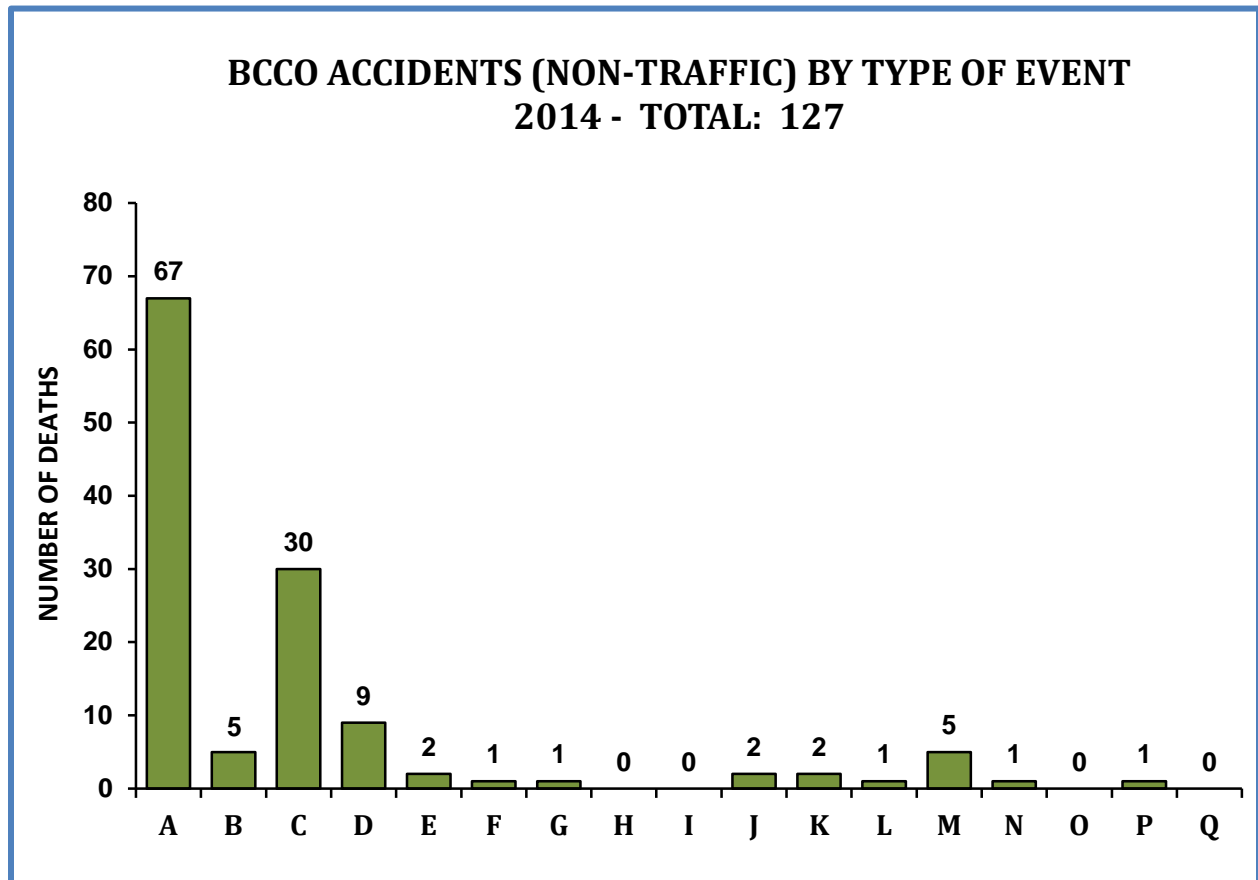
There was 1 pedestrian case that tested positive for THC that did not test positive for Alcohol.



Note: There were a total of 156 non-traffic accidents reported to the Boulder County Coroner's Office in 2014. The Boulder County Coroner's Office investigated 127 of those cases and transferred jurisdiction of 29 cases to other coroners.

**BCCO ACCIDENTAL DEATHS (NON-TRAFFIC) BY MONTH
2014 - TOTAL: 127**

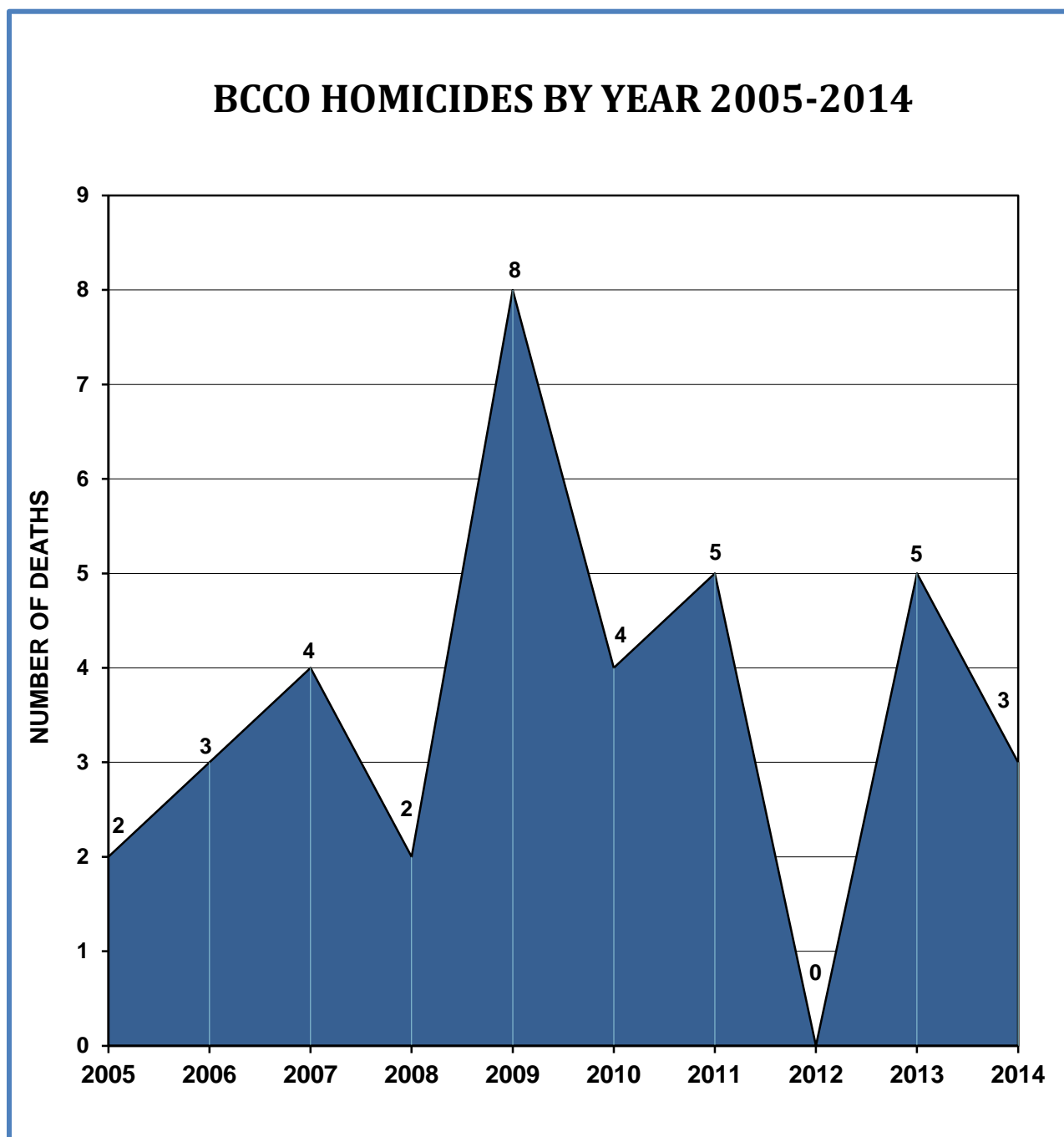


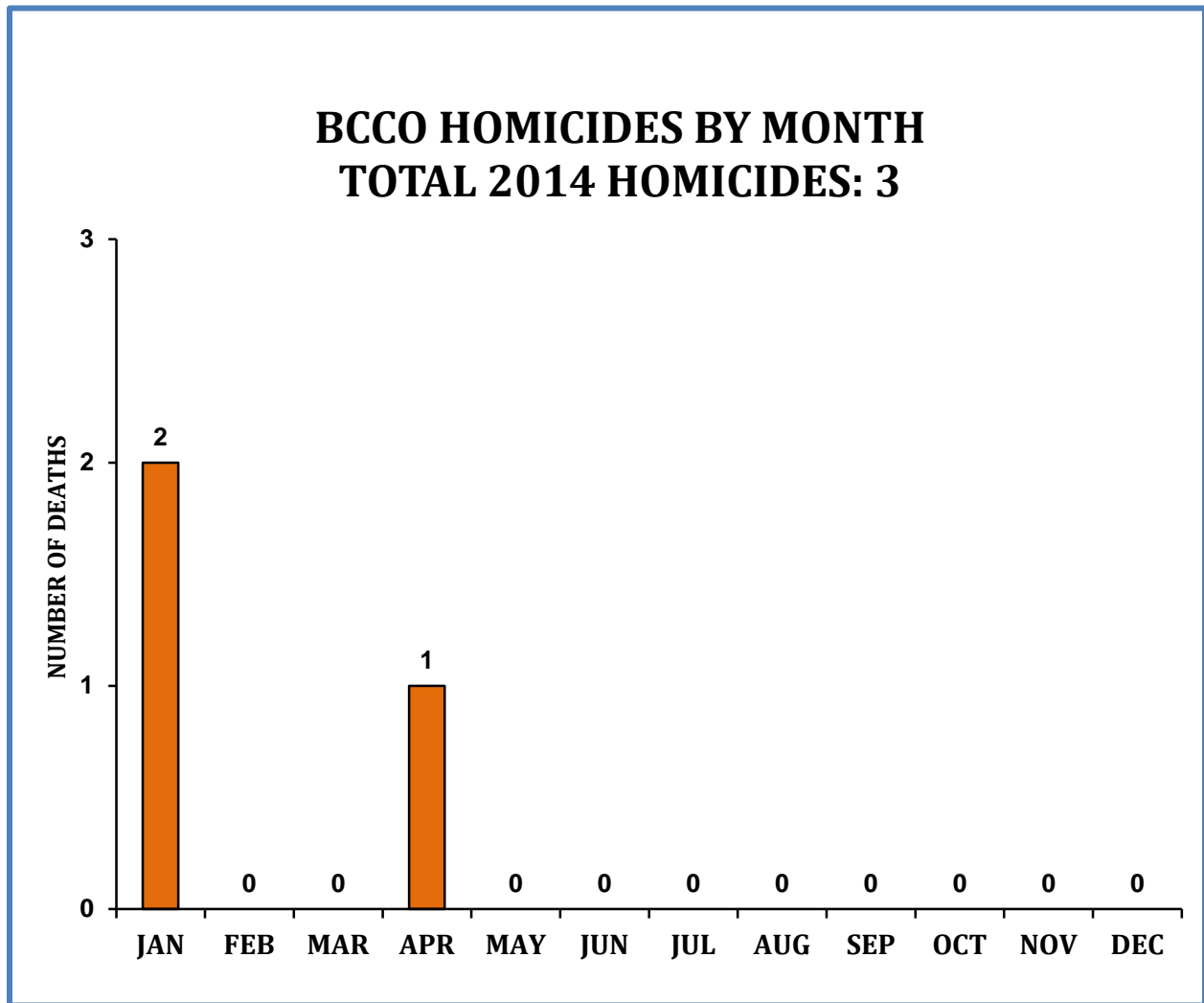


LEGEND:

A - Fall (Non-Recreational)
B - Fall/Recreational
C - Drug Overdose (All Types)
D - Drug Overdose in combination with Alcohol
E - Alcohol
F - Positional Asphyxia
G - Drowning
H - Electrocutation
I - Fall from Height
J - Aspirated on Food
K - Medical Misadventure
L - Airplane Crash
M - Environmental
N - Thermal Injuries
O - Blunt Force Injuries
P - Hit by Train
Q - Unknown

HOMICIDES BY YEAR



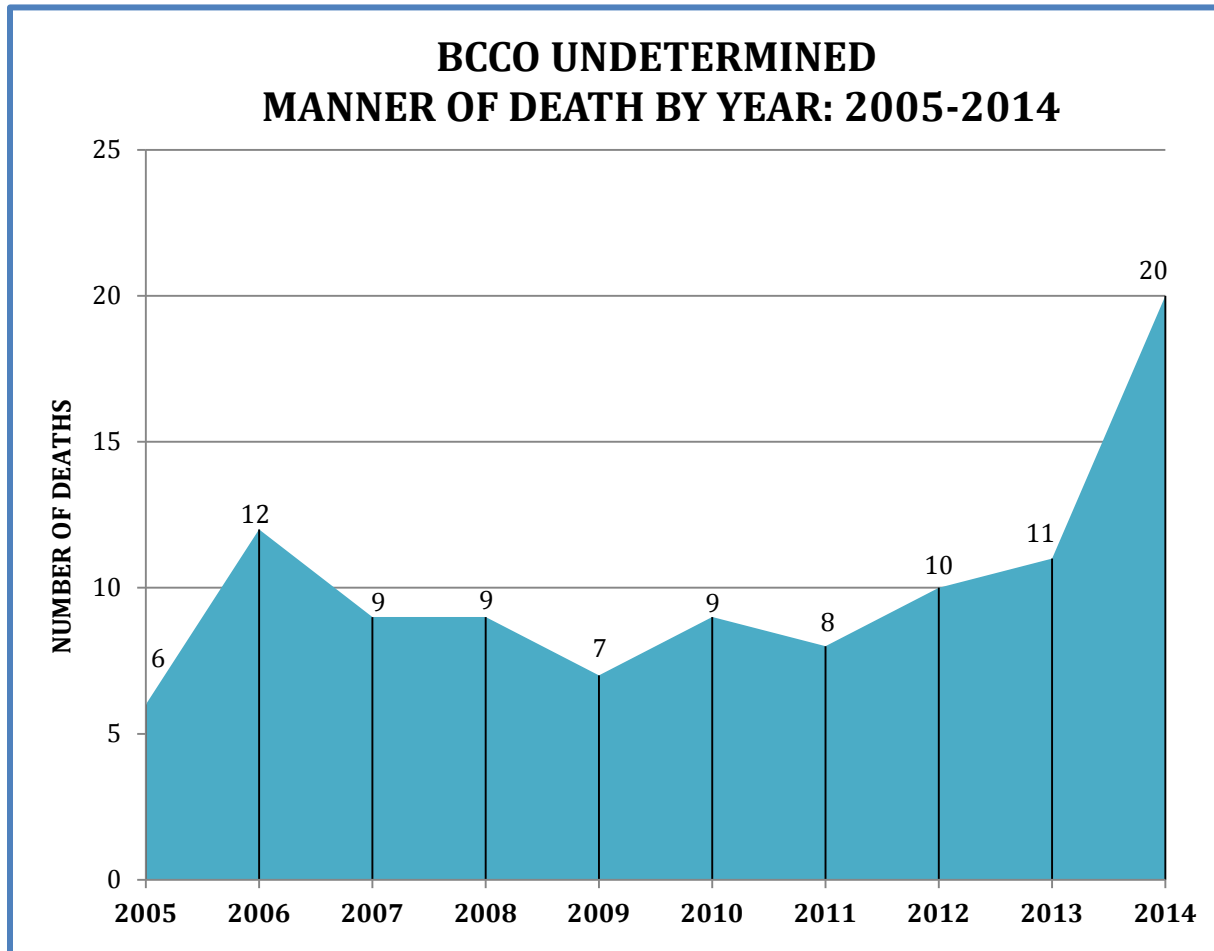


Note: In 2014, all three of the victims of homicide were male. Two homicide victims died of a stab wounds, the third victim died of blunt trauma to the head from an assault.

DEATHS OF UNDETERMINED MANNER

Occasionally, medical examiners and coroners encounter cases that, despite a complete autopsy, comprehensive toxicology tests, and a thorough scene investigation, no cause of death can be determined. Medical examiners and coroners also encounter cases where the cause of death is quite apparent; but the evidence supporting the manner of death is equivocal or insufficient to make a determination. The determination of manner of death is an opinion based on the “preponderance of evidence”. An example might be a case in which the cause of death is a drug overdose, but, from the information available, it is not certain whether the manner of death is accident or suicide. Therefore, the manner of death may be certified as undetermined.

UNDETERMINED MANNER BY YEAR

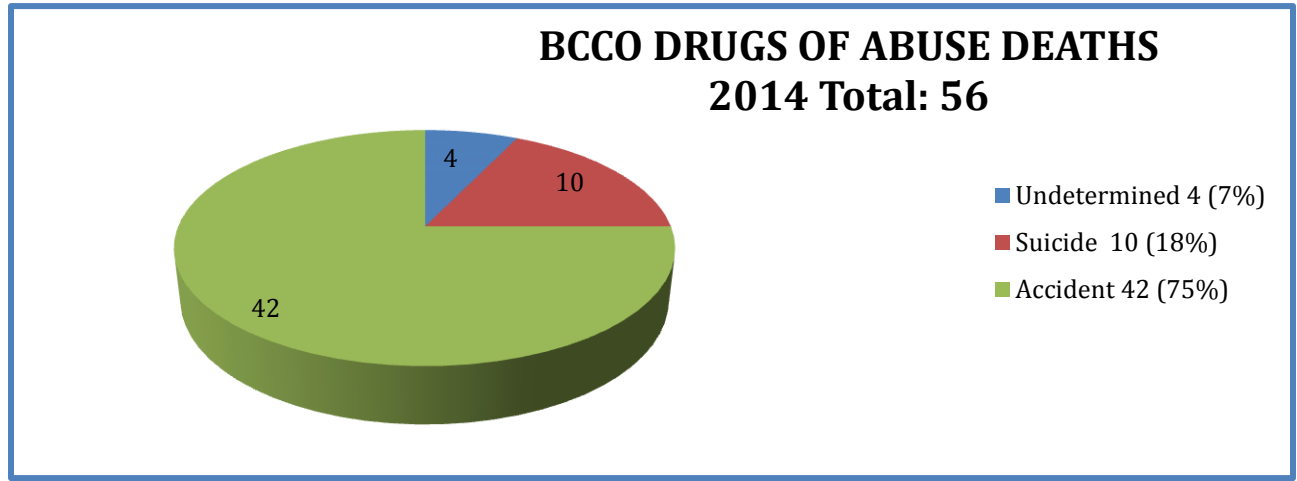


Note: There were a total of 21 cases reported to the Boulder County Coroner’s Office in 2014 that were ruled as an undetermined manner of death; one of these cases was transferred to another coroner’s office who made the undetermined ruling for that case. The Boulder County Coroner’s Office investigated the other 20 cases.

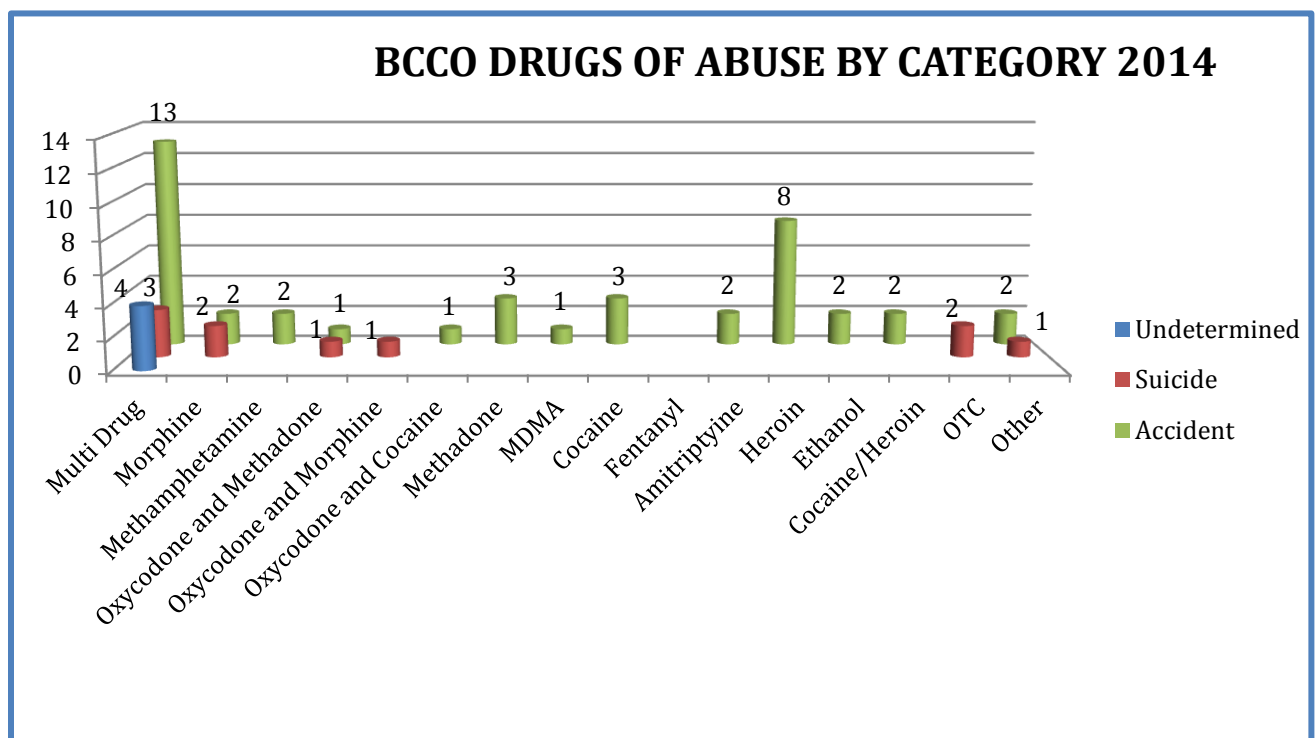
While the office ruled undetermined for the manner of death in 20 cases in 2014, only two of those cases listed an undetermined cause of death as well; one was due to the advanced level of decomposition and the other case was where a transient was found partially submerged in a drainage ditch and a clear cause of death could not be determined. In the other eighteen cases more information was known about the cause of death; 8 cases were related to trauma, 4 were related to drug overdoses, 1 was related to medical care, and 5 cases were listed as Sudden Unexpected Infant Death (4 of which occurred during an unsafe sleep environment).

DRUG DEATHS

DRUG DEATHS BY MANNER



DRUGS OF ABUSE BY CATEGORY



Note: Boulder County saw a large increase in heroin related deaths starting in 2013 with a total of 15 cases, up from 6 in 2012. In 2014 there were a total of 13 heroin related deaths, 2 of them are listed above in the Multi Drug category. The Multi Drug category is used for cases where a couple of drugs or several drugs are responsible for the death. Of the cases listed in the Multi Drug section the drugs of interest that were present were: morphine (1 case), methadone (3 cases), cocaine (1 case), fentanyl (7 cases), and heroin (3 cases). Of note there were 2 cases in which heroin and fentanyl were present with a combination of other drugs as well.

DROWNINGS

Drowning as a cause of death is a diagnosis of exclusion, diagnosis of exclusion is described as a diagnosis of a medical condition that is reached by eliminating all other possible diagnoses. If an individual is found in water and all other possible causes of death have been excluded, one *may* be able to conclude the cause of death is drowning. Presumed drowning cases require complete autopsies, in order to exclude all other causes of death.

In 2014 there were three total drowning cases. All three of the cases were ruled Accidents. One of the drownings occurred in combination with substance usage/abuse. One was as a result of trying to rescue a dog in a creek and the third occurred following a roll-over traffic accident, where the vehicle ended up in a creek.

CHILD DEATHS

In 2013 Senate Bill 13-255 passed mandating that starting January 1st, 2015 each county form a local Child Fatality Review and Prevention Team. Moving the reviews to local teams from the state team would create a broader scope, with the state mandating which cases would be reviewed (birth – 17) that involve unintentional injury, violence, motor vehicle incident, child abuse/neglect, sudden unexpected infant death, suicide or undetermined cases. The teams provide the state with individual case findings to develop community approach to issues surrounding child deaths. They review manner and cause of death and evaluate the means by which the fatality might have been prevented. The teams report case findings to public/private agencies that have responsibilities for children and make prevention recommendations to reduce the number of child fatalities.

Each team must consist of the following:

- Each county department
- Local law enforcement agencies
- DA
- School districts
- County public health
- Coroner's office
- County attorney's office

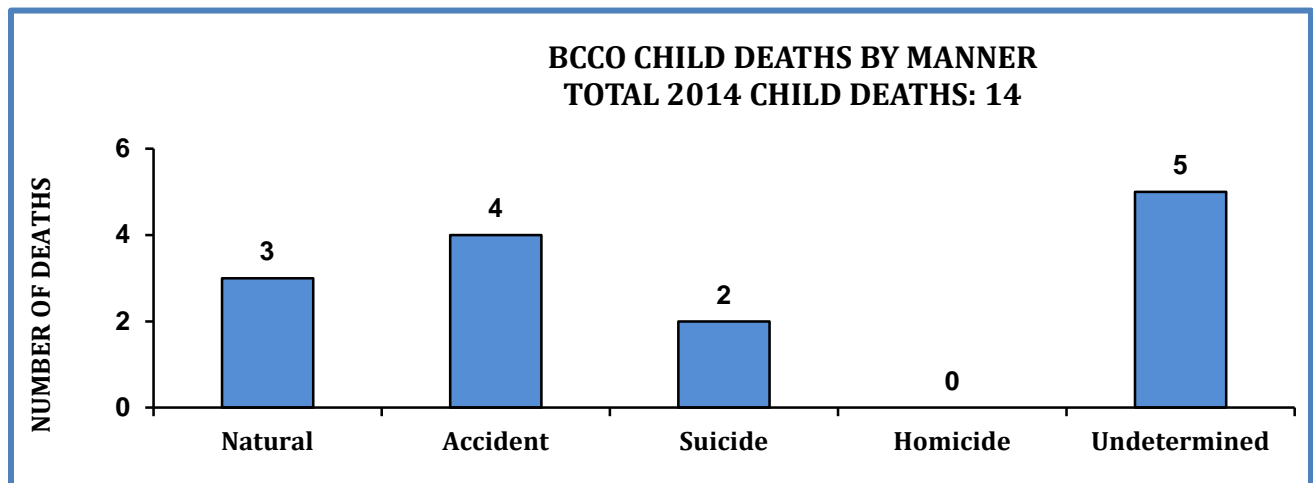
Additional agencies that may be included are: Hospitals or other emergency medical services, Social services, Mental health professionals, Pediatricians, Child advocacy centers, and Victim advocates.

In 2014 the office worked closely with the Public Health Department to bring the agencies together so that the team could start reviewing the 2014 child deaths starting in January of 2015. Public Health asked the Coroner's Office to become the coordinator for the team; currently Boulder County is the only county in Colorado to participate in this way as the coordinator.

In Boulder County a total of fourteen child deaths (<18 years of age) were reported to the Coroner's Office in 2014. Six additional child death cases were transferred to other coroners.

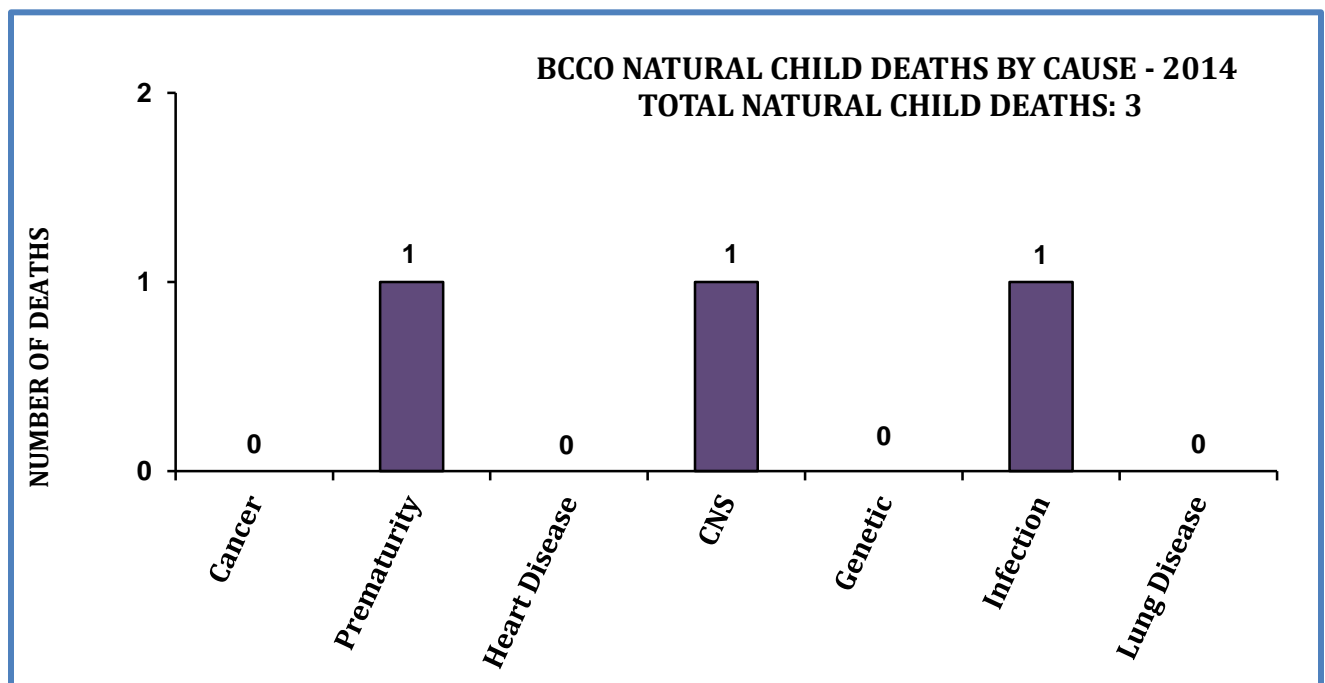
Note: Statistical information may not coincide with information available from the Colorado Health Department. The State Health Department tracks death statistics by the county of residence, not by the county in which the injury or death occurred.

CHILD DEATHS BY MANNER OF DEATH



- **Accident:** One of the accidental deaths was drowning following a vehicle incident (age 13); one was the result of a medical procedure during a complicated childbirth (age 3); one was from thermal injuries sustained during a residential fire (age 1yr 11months); the fourth one was due to positional asphyxia associated with unsafe sleep environment (8 months)
- **Suicide:** One of the suicide deaths was a result of a self-inflicted gunshot wound (age 17), and the other was a result of a hanging (age 16).
- **Undetermined:** All five of the undetermined deaths were ruled as Sudden Unexpected Infant Death. Four of the Five were associated with unsafe sleep environments (ages: 4 months, 1 month 9 days, 7 weeks and 4 months). The one case that had negative findings for an unsafe sleep environment was age 3 months 22 days.

CHILD DEATHS BY CAUSE OF NATURAL DEATHS




SUDDEN UNEXPLAINED INFANT DEATH (SUID) AND SUDDEN INFANT DEATH SYNDROME (SIDS)

The Center for Disease Control and Prevention (CDC) defines sudden unexplained infant death (SUID) as deaths in infants less than 1 year of age that occur suddenly and unexpectedly, and whose cause of death are not immediately obvious prior to investigation. The CDC defines sudden infant death syndrome (SIDS) as the sudden death of an infant less than 1 year of age whose cause of death cannot be explained after a thorough investigation is conducted, including a complete autopsy, examination of the death scene, and review of the clinical history. While the CDC has separate definitions for these two terms the classification of the manner of death and written description of the cause of death in these types of cases do vary throughout the nation.

SIDS is a diagnosis of exclusion, diagnosis of exclusion is described as a diagnosis of a medical condition that is reached by eliminating all other diagnoses. Therefore to determine the cause of death is SIDS, a coroner or medical examiner must conduct a thorough case investigation which includes examination of the death scene, including the sleeping environment and bedding, a review of the medical history, perform a complete autopsy and further testing. These cases are a collaborative effort with law enforcement and at times the District Attorney's Office. Once a thorough investigation is conducted and no other possible cause of death is determined only then *may* a determination of SIDS be made. Many times when a thorough case investigation is conducted an explanation is found, such as natural disease or disorder, positional asphyxia, suffocation, hyper or hypothermia, neglect, homicide, etc. Other times there may be signs of potential issues but no clear and obvious reason for death, most often the finding of an unsafe sleep environment is found. At times there may be no indication of potential issues and the cause of death is truly unknown.

The American Academy of Pediatrics (AAP) started its "Back to Sleep" campaign in 1992 informing the public of its recommendation that infants be placed for sleep in a non-prone position on their back, in an effort to prevent SIDS deaths. The CDC makes ongoing efforts to prevent SUID and SIDS deaths and on October 17, 2011 they published a new statement on SIDS, which stated that there has been a major decrease in the incidence of SIDS since 1992, however the decline has plateaued in recent years. In the 2011 statement AAP reported that since their previous statement on SIDS in 2005 they have seen an increase in SUID deaths occurring during sleep. Therefore the AAP expanded its recommendations to focus on safe sleep environments that can reduce the risk of all sleep-related infant deaths including SIDS. Their recommendations include: supine positioning, use of a firm sleep surface, breastfeeding, room-sharing without bed-sharing, routine immunization, consideration of a pacifier, and avoidance of soft bedding, overheating, and exposure to tobacco smoke, alcohol, and illicit drugs.³



Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

POLICY STATEMENT

SIDS and Other Sleep-Related Infant Deaths: Expansion of Recommendations for a Safe Infant Sleeping Environment

abstract

Despite a major decrease in the incidence of sudden infant death syndrome (SIDS) since the American Academy of Pediatrics (AAP) released its recommendation in 1992 that infants be placed for sleep in a non-prone position, this decline has plateaued in recent years. Concurrently, other causes of sudden unexpected infant death that occur during sleep (sleep-related deaths), including suffocation, asphyxia, and entrapment, and ill-defined or unspecified causes of death have increased in incidence, particularly since the AAP published its last statement on SIDS in 2005. It has become increasingly important to address these other causes of sleep-related infant death. Many of the modifiable and nonmodifiable risk factors for SIDS and suffocation are strikingly similar. The AAP, therefore, is expanding its recommendations from focusing only on SIDS to focusing on a safe sleep environment that can reduce the risk of all sleep-related infant deaths, including SIDS. The recommendations described in this policy statement include supine positioning, use of a firm sleep surface, breastfeeding, room-sharing without bed-sharing, routine immunizations, consideration of using a pacifier, and avoidance of soft bedding, overheating, and exposure to tobacco smoke, alcohol, and illicit drugs. The rationale for these recommendations is discussed in detail in the accompanying "Technical Report—SIDS and Other Sleep-Related Infant Deaths: Expansion of Recommendations for a Safe Infant Sleeping Environment," which is included in this issue of *Pediatrics* (www.pediatrics.org/cgi/content/full/129/5/e1341). *Pediatrics* 2011;129:1030–1039

INTRODUCTION

Sudden infant death syndrome (SIDS) is a cause assigned to infant deaths that cannot be explained after a thorough case investigation, including a scene investigation, autopsy, and review of the clinical history.¹ Sudden unexpected infant death (SUID), also known as sudden unexpected death in infancy, is a term used to describe any sudden and unexpected death, whether explained or unexplained (including SIDS), that occurs during infancy. After case investigation, SUIDs can be attributed to suffocation, asphyxia, entrapment, infection, ingestions, metabolic diseases, arrhythmia-associated cardiac channelopathies, and trauma (accidental or nonaccidental). The distinction between SIDS and other SUIDs, particularly those that occur during an observed or unobserved sleep period (sleep-related infant deaths), such as ac-

KEY WORDS

SIDS—sudden infant death; infant mortality; sleep position; bed-sharing; tobacco; pacifier; immunization; bedding; sleep surface

ABBREVIATIONS

SIDS—sudden infant death syndrome
SUID—sudden unexpected infant death
AAP—American Academy of Pediatrics

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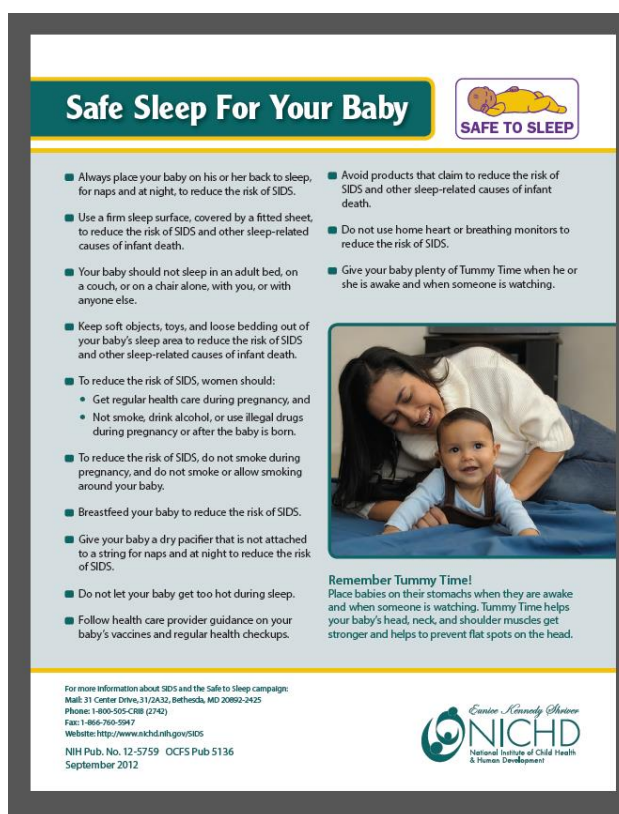
www.pediatrics.org/cgi/doi/10.1542/peds.2011.2284
doi:10.1542/peds.2011.2284

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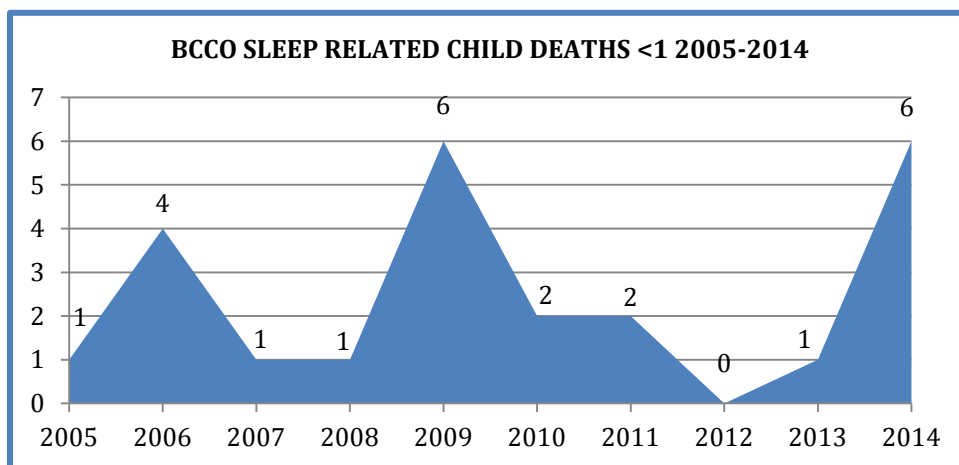
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Ongoing efforts to encourage safe sleep environments are also being made by CDC and the National Institute of Child Health and Human Development (NICHD). The NICHD among other literature has published brochures advertising safe sleep. Many of these resources can be found on the CDC's website www.cdc.gov. An example is provided below.



10 YEAR CHILD DEATH STUDY

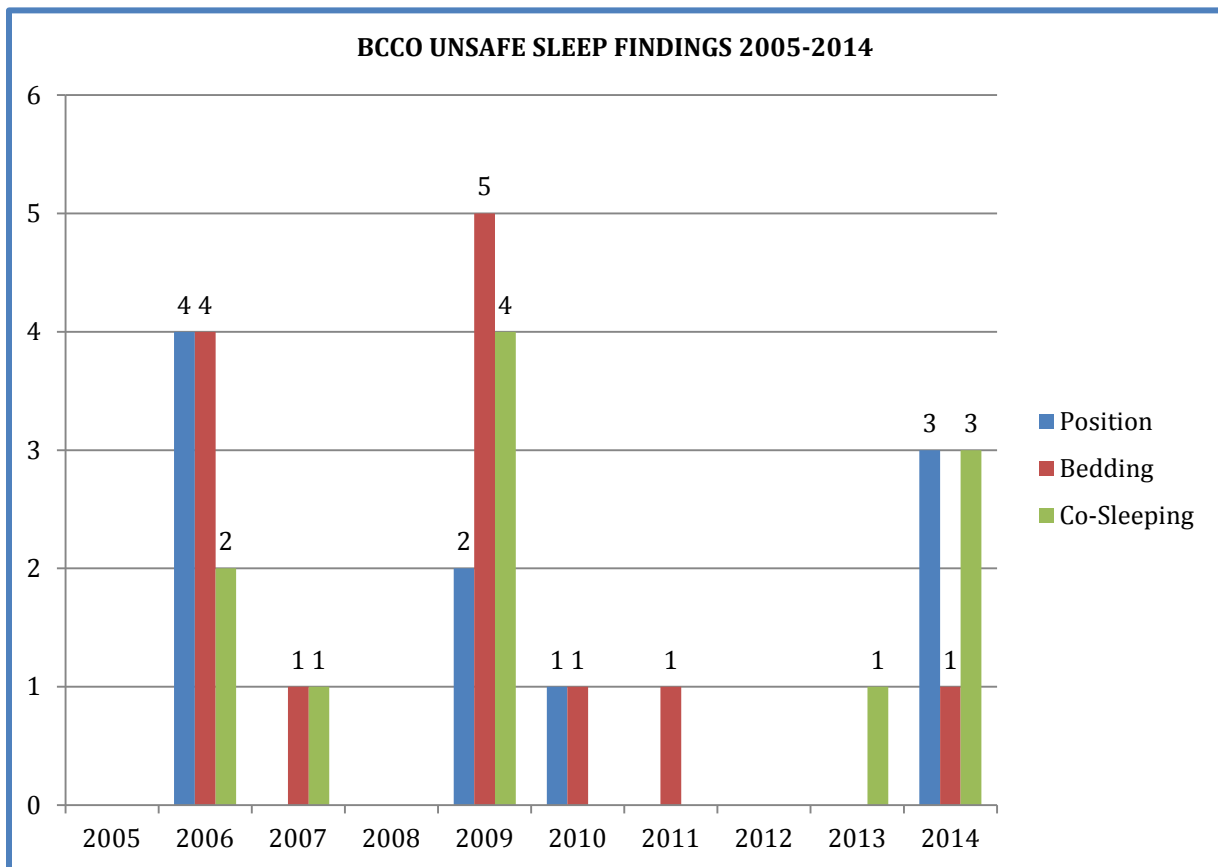
With the increase in Boulder County child deaths in 2014 and the inconsistent use of terminology over the years in describing SIDS and/or SUID deaths, a 10 year child death study was conducted for inclusion in this year's report. The cases that were included in this study were children under the age of 1 year that died in their sleep. There were a total of 24 cases included in this study.



UNSAFE SLEEP FINDINGS IN 10 YEAR CHILD DEATH STUDY

There were five cases that after a review of the case documentation the unsafe sleep findings were categorized as unknown, not ideal, or undetermined; however the other 19 cases all had at least one finding of an unsafe sleep environment, many of them had more than one finding. The below graph shows the findings by occurrence by three types of unsafe sleep categories: position, bedding, and co-sleeping. The non-recommended position the infant was placed in most often was on the stomach.

Of the 24 cases the law enforcement jurisdiction were as follows: Boulder County Sheriff's Office – 3, Boulder PD – 3, Lafayette PD – 2, Longmont – 12, and Louisville – 4. There were 11 females and 13 males. The ages were as follows: the youngest case was less than 1 month at 13 days, there were 9 cases from 1-3 months, 10 cases from 3-6 months and 4 cases from 6-9 months (the oldest was just over 8 months). The ethnicities of the children were as follows: Caucasian – 21, African American – 2, and Hispanic – 1.



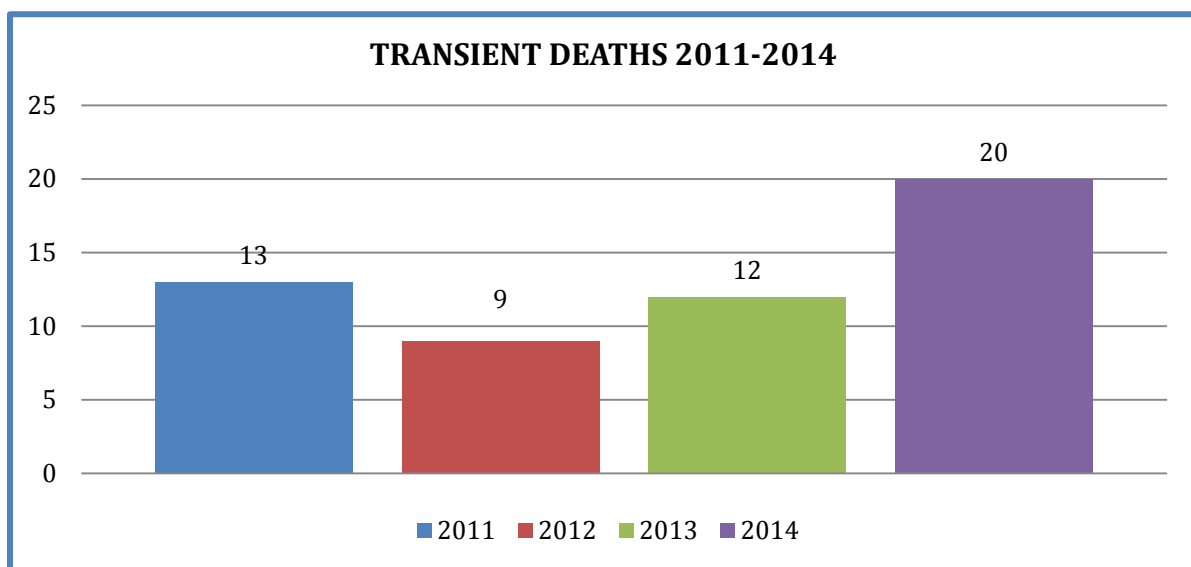
Based on the cases included in this 10 year child death study Boulder County is a prime location for additional support and promotion of safe sleep environments for infants. As these cases are continued to be reviewed by the local Boulder County Child Fatality and Prevention Team, more recommendations will be made to the state of preventing these types of child fatalities.

In the 11 cases where co-sleeping was a finding, the toxicology levels are unknown of the individual with whom the infant was co-sleeping with; however from 2009 to 2014 in 4 of the 5 cases there was suspicion or self-reporting of use of alcohol, drugs, prescription drugs or a combination of.

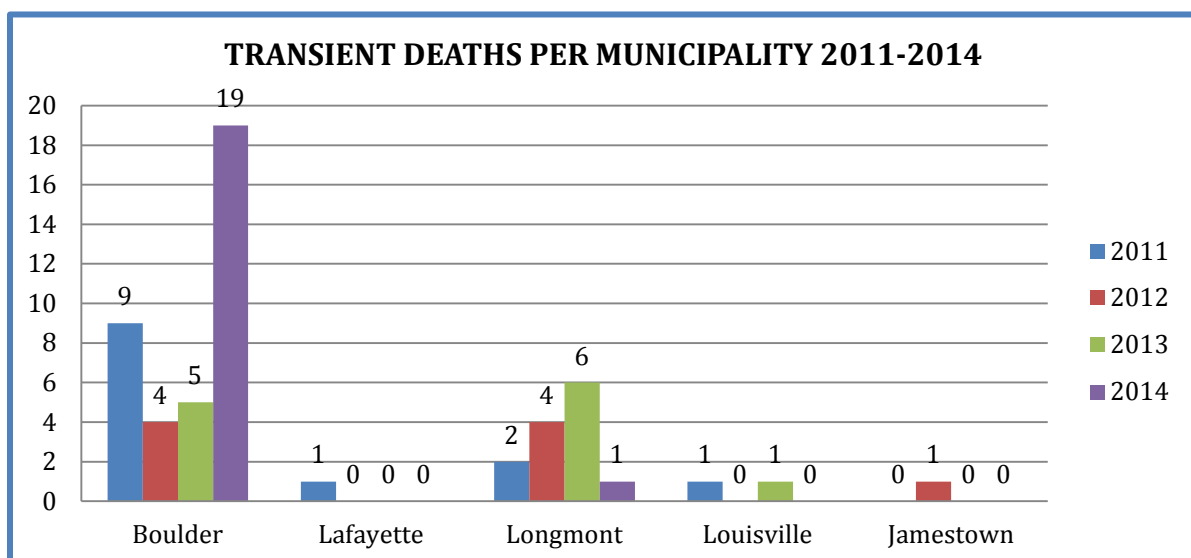
TRANSIENT/HOMELESS DEATHS

The Boulder County Coroner's Office started to notice an increase in the amount of transient/homeless deaths in the city of Boulder mid-year 2014. Due to the increase a mid-year detailed report was created to offer information to city and county leaders as well as the public on these types of deaths. While the office did its best to track these kinds of deaths to have the best possible information it should be noted that not all deaths that occur in Boulder County are reported to the Coroner's Office. An example of this would be if a person dies at a nursing home or more than 24 hours after being admitted to a hospital, the death may not be reported if the person dies of natural causes. Also, not all transients that die are reported as having lived on the streets at the time their death is reported. For example, a nurse reporting the death of a person who dies under hospice care or in a care facility may not necessarily know that the person was homeless at a point prior to their admission. Therefore the total number of transient deaths on file at the coroner's office may vary from numbers on file with other organizations. That being said the following covers a few stats on what information is available.

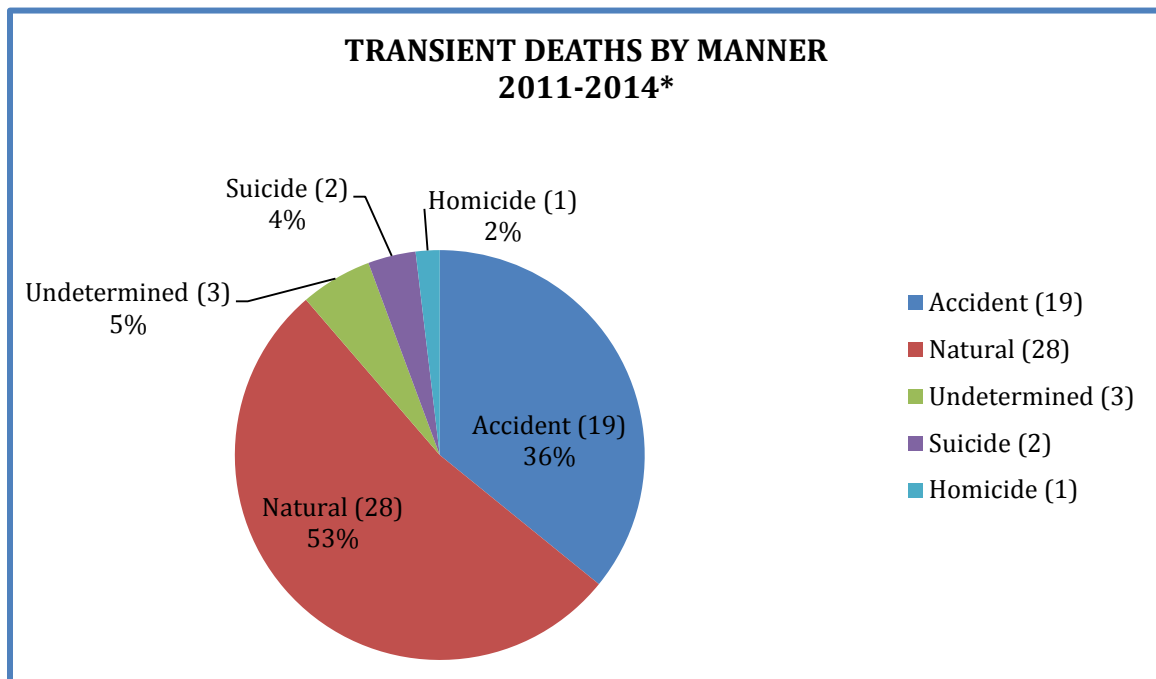
TRANSIENT DEATHS BY YEAR



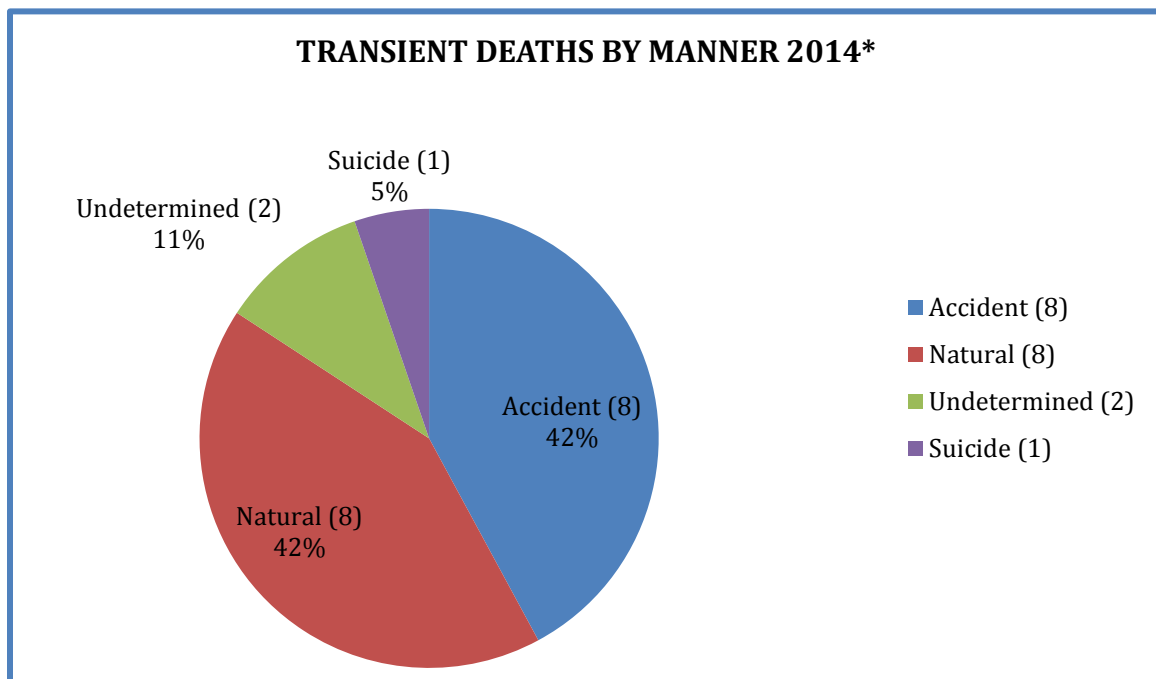
TRANSIENT DEATHS PER MUNICIPALITY



TRANSIENT DEATHS BY MANNER OF DEATH 2011-2014

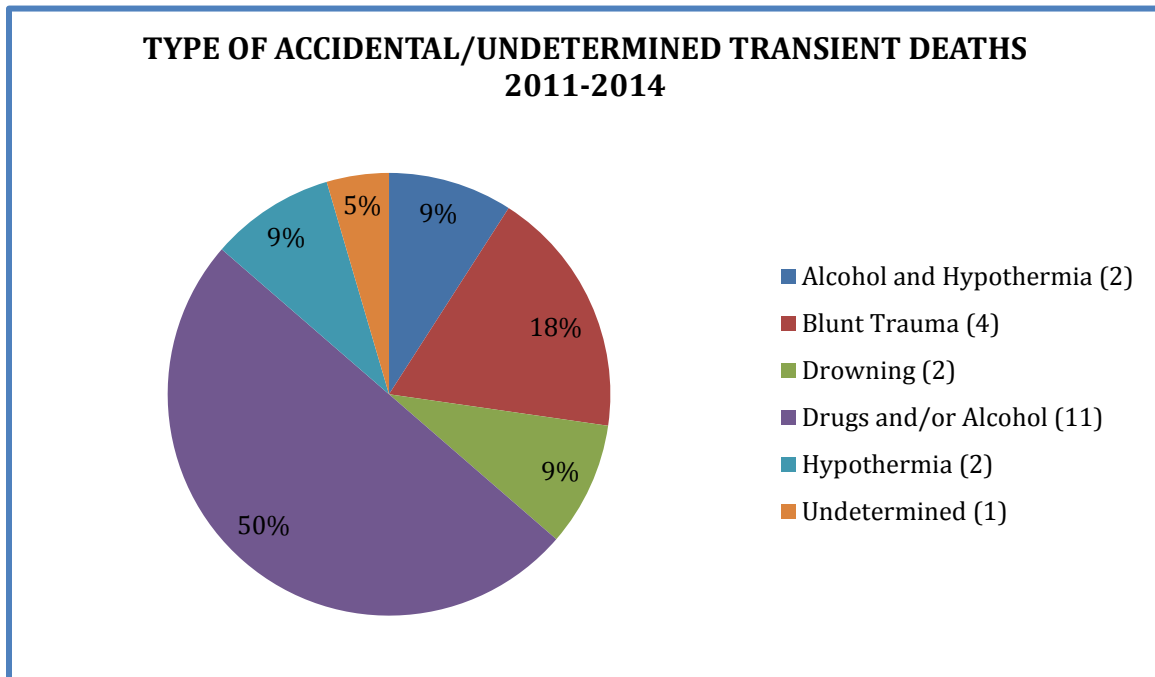


TRANSIENT DEATHS BY MANNER OF DEATH 2014



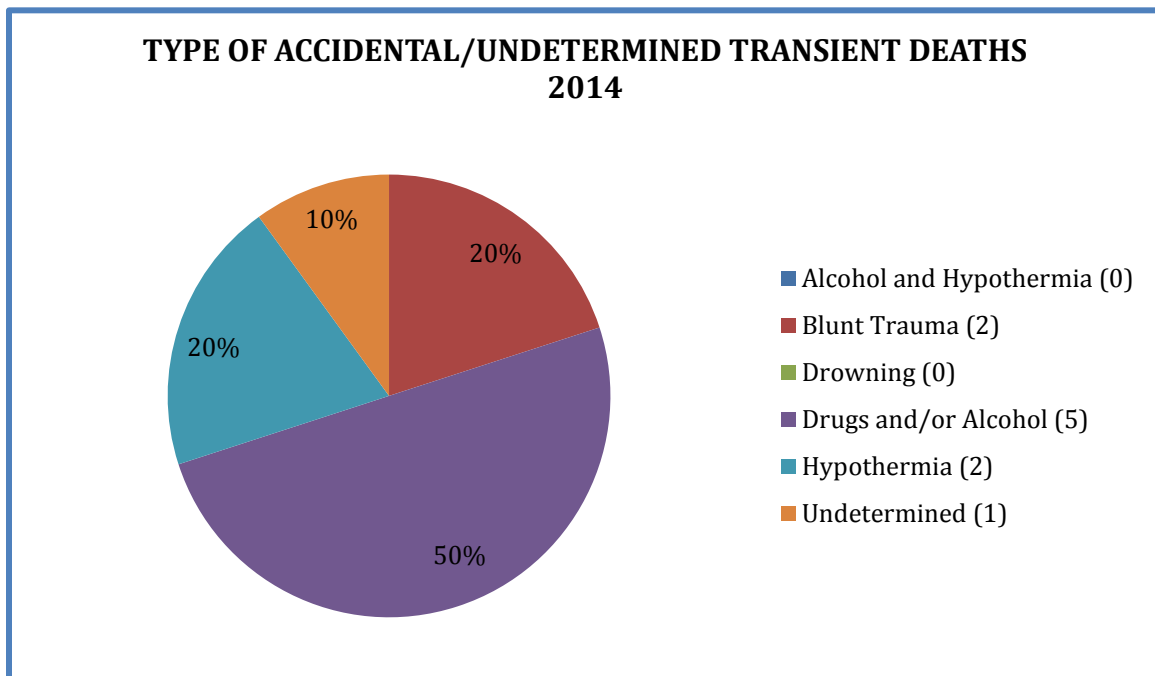
Note: One case from 2014 was a fetal demise; therefore no manner of death was assigned.

TYPE OF ACCIDENTAL/UNDETERMINED TRANSIENT DEATHS 2011-2014



Note: Of the transient/homeless deaths tracked from 2011 to 2014, 43 were male and 10 were female, one case was a fetal demise of a transient female. Ages of the decedents over the years ranged from 27 to 78.

TYPE OF ACCIDENTAL/UNDETERMINED TRANSIENT DEATHS 2014

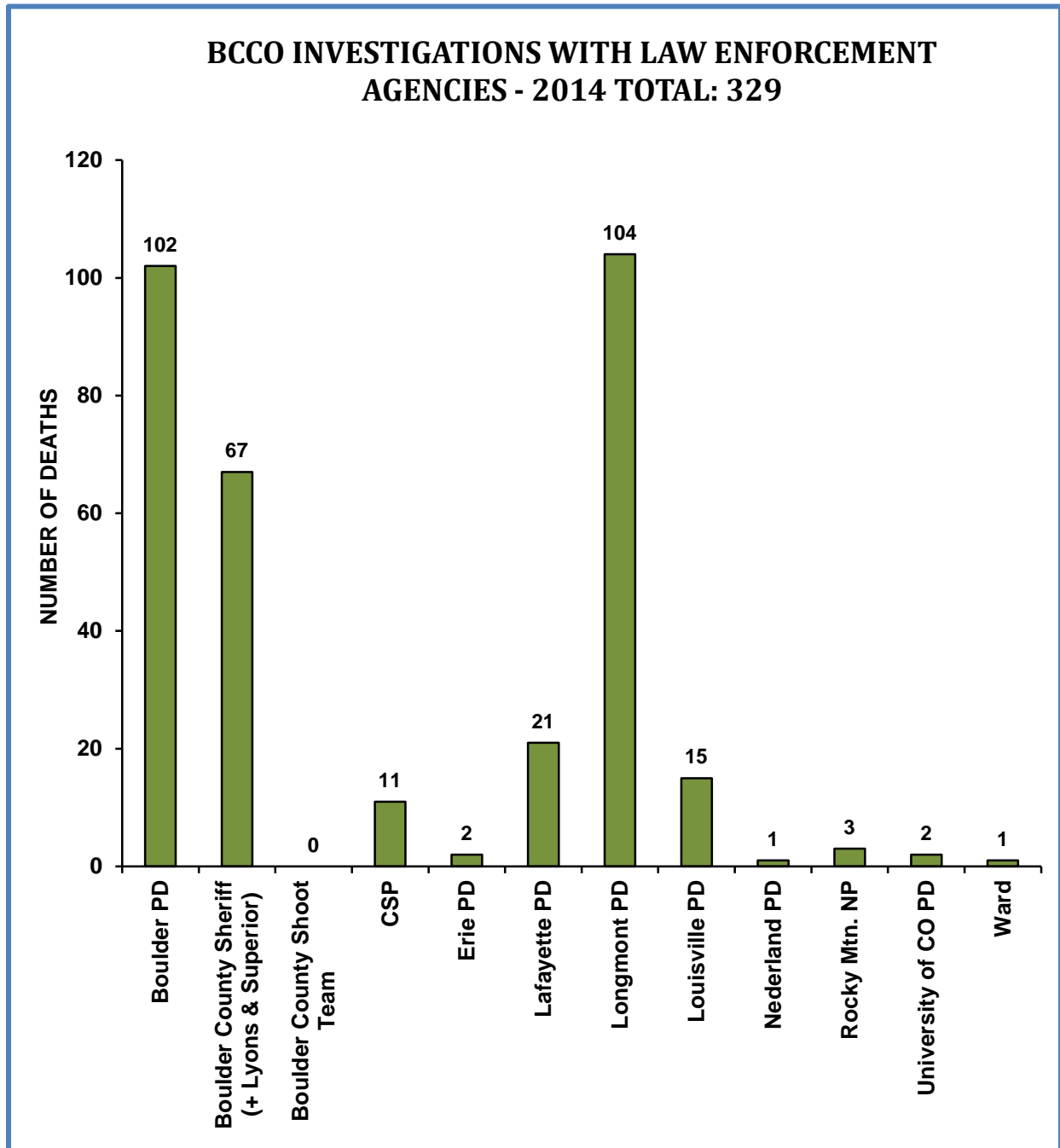


Note: Of the transient/homeless deaths tracked in 2014, 14 were male and 5 were female, one case was a fetal demise of a transient female. Ages of the decedents in 2014 ranged from 27 to 78.

LAW ENFORCEMENT

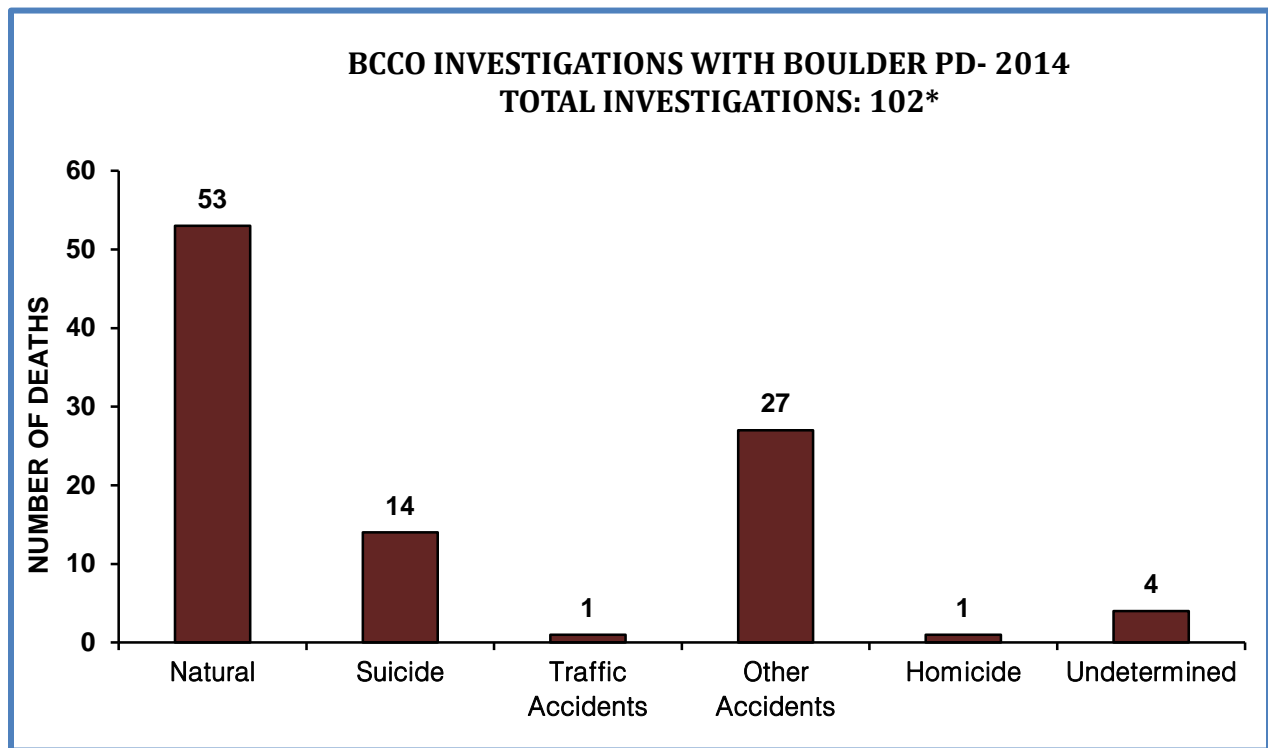
The Boulder County Coroner's Office works with the law enforcement agencies that cover jurisdiction in Boulder County. The charts in this section show the number of cases investigated with these agencies. Please note that the number of investigations listed may differ from those in the "Coroner Response" section of this report because the coroner's office also works with law enforcement on cases in which people die in the hospital as a delayed result of non-natural circumstances (i.e. auto incidents).

INVESTIGATIONS WITH LAW ENFORCEMENT AGENCIES



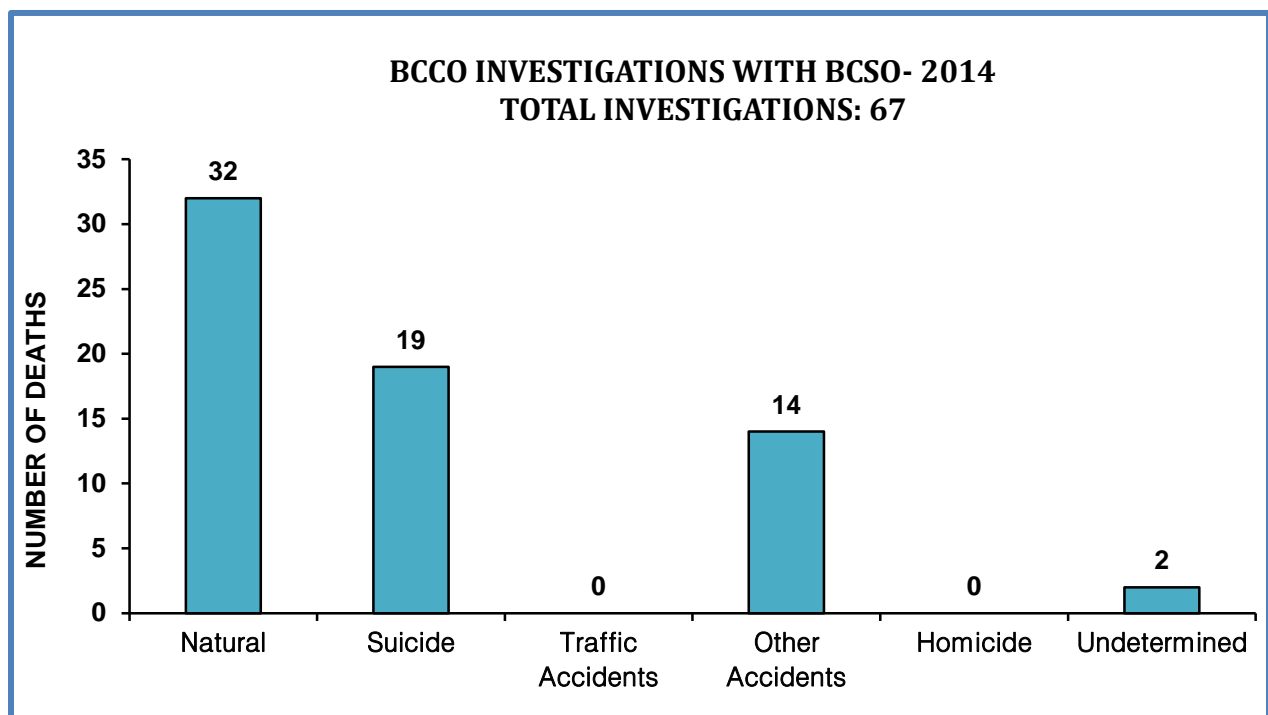
Note: The jurisdiction of the Boulder County Sheriff's Department includes unincorporated areas of Boulder County and the towns of Superior and Lyons.

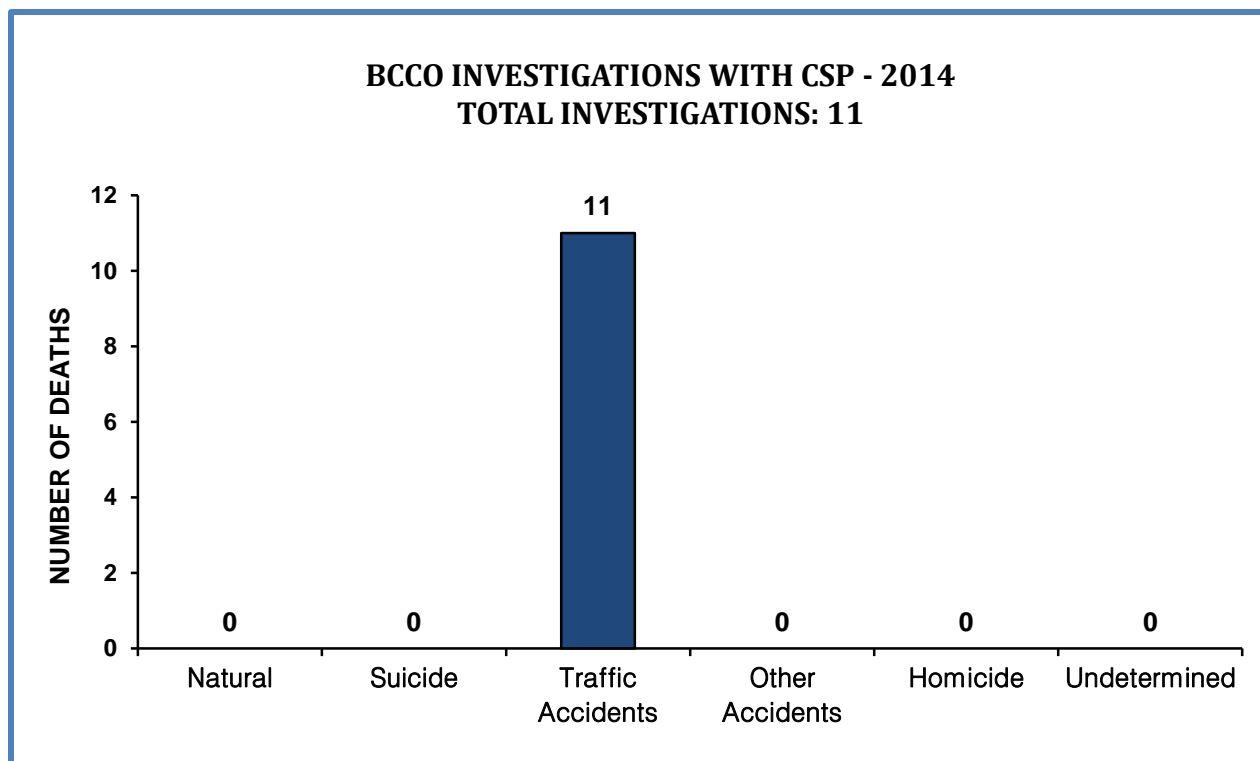
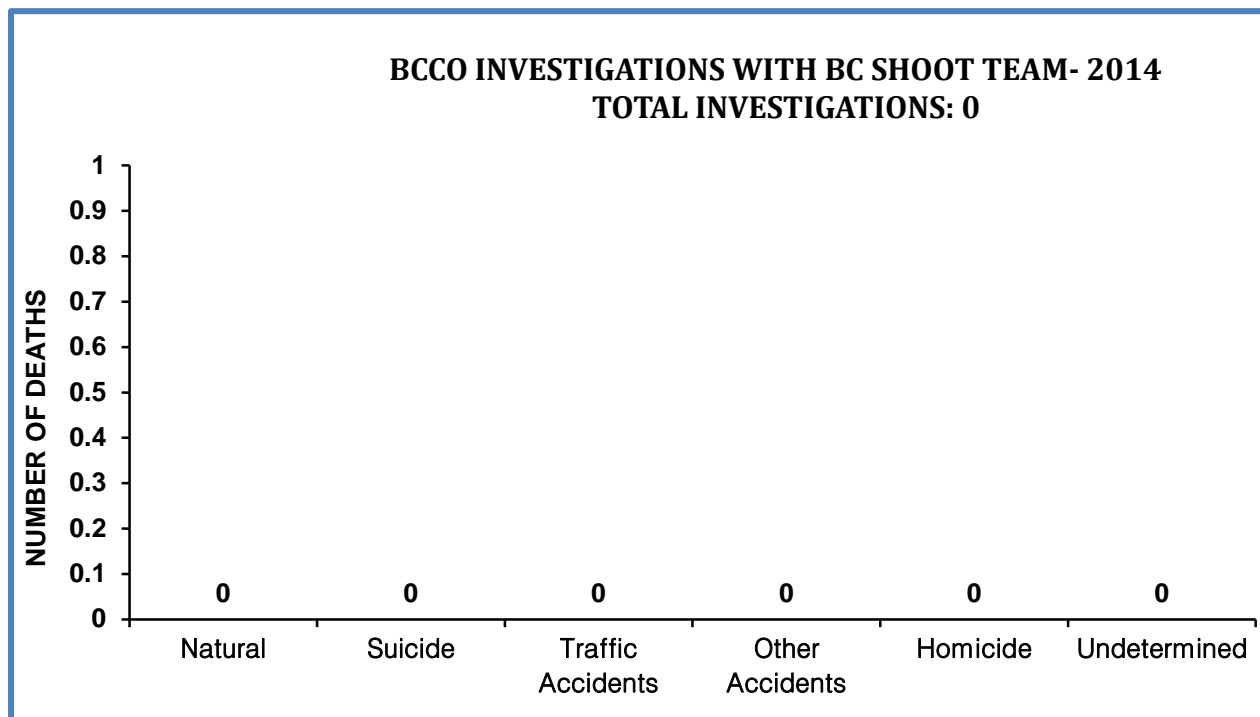
BOULDER POLICE DEPARTMENT

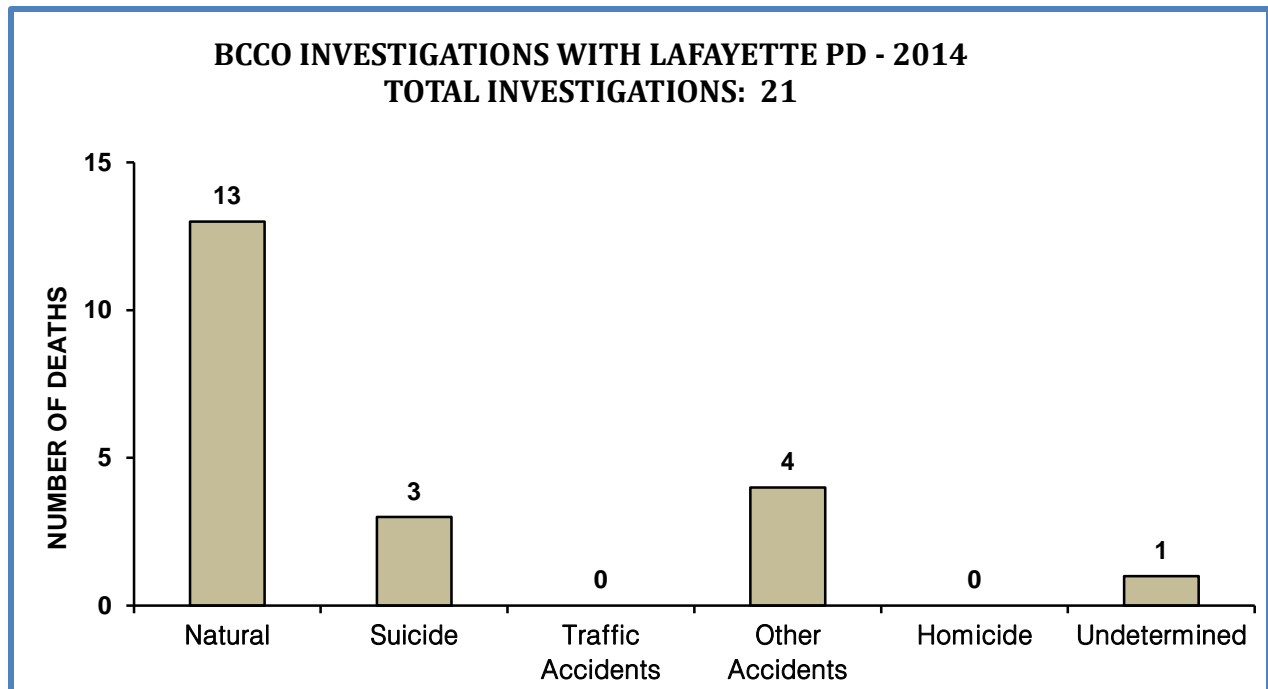
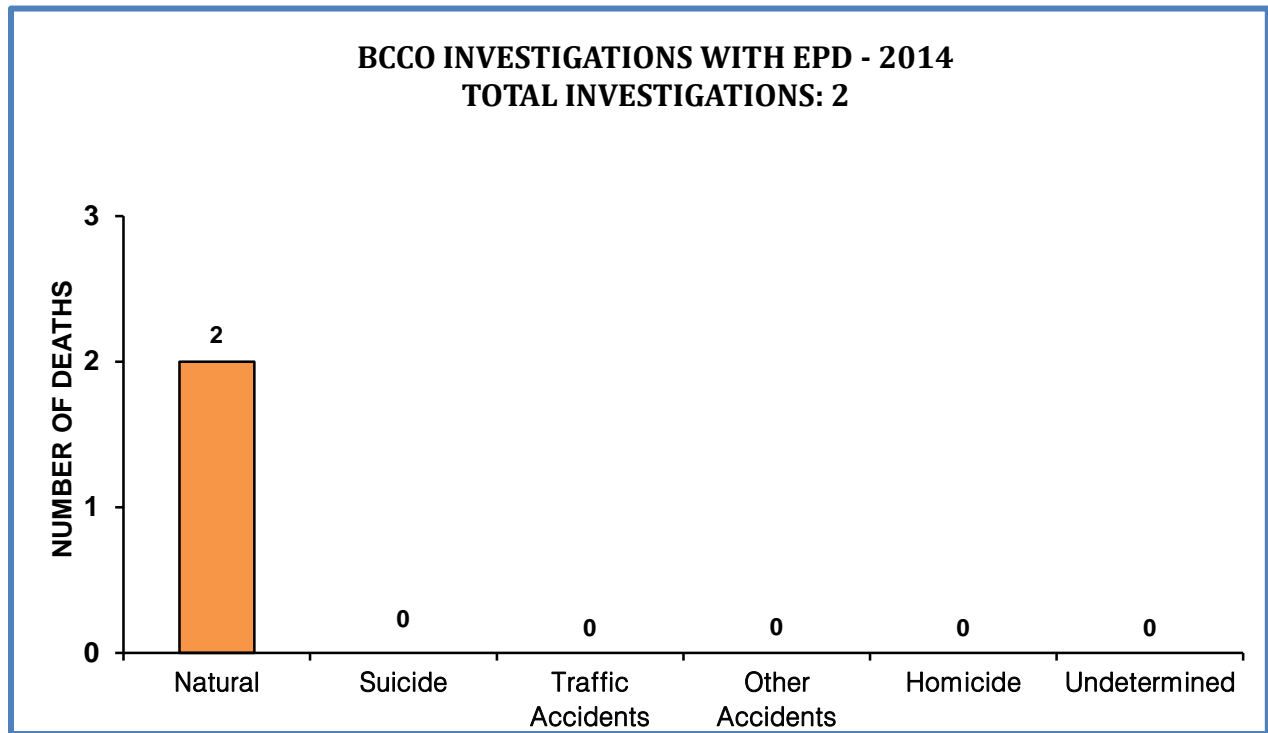


Note: *There are two investigations with Boulder Police Department that are not reflected in the above graph, both cases were fetal demise cases in which a manner of death is not assigned.

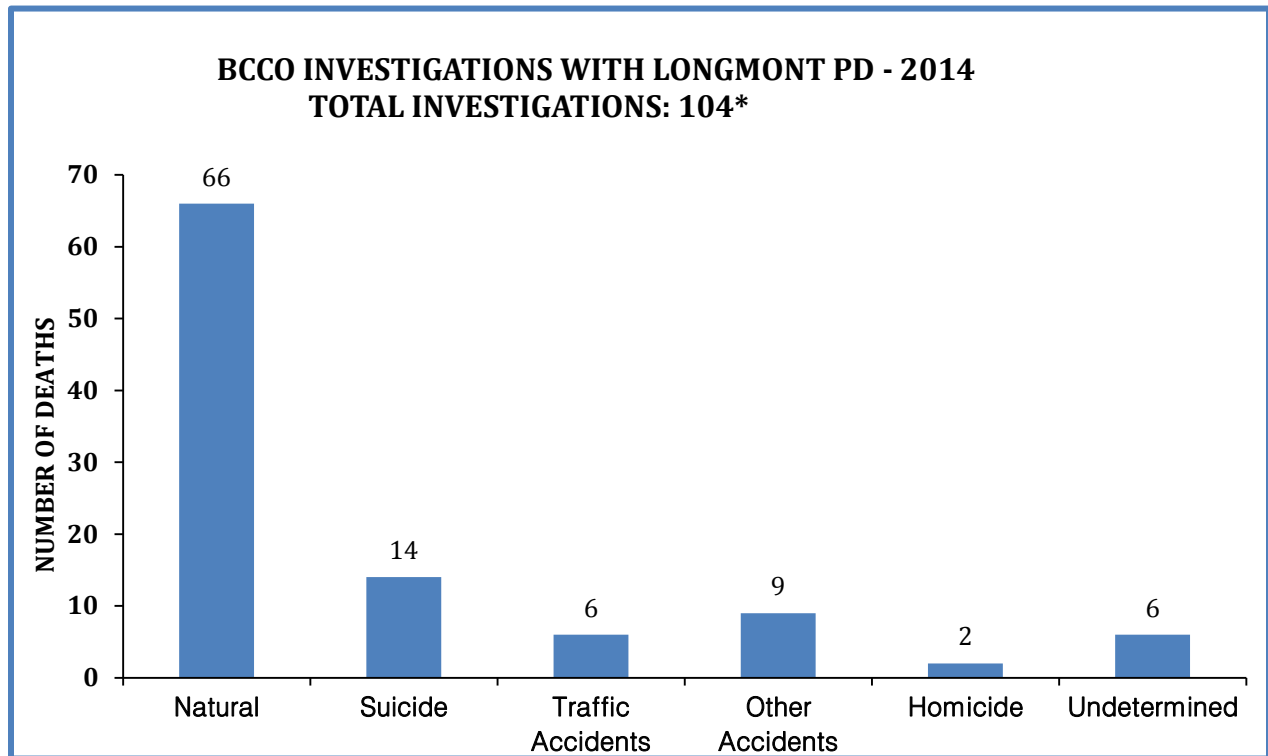
BOULDER COUNTY SHERIFF'S OFFICE





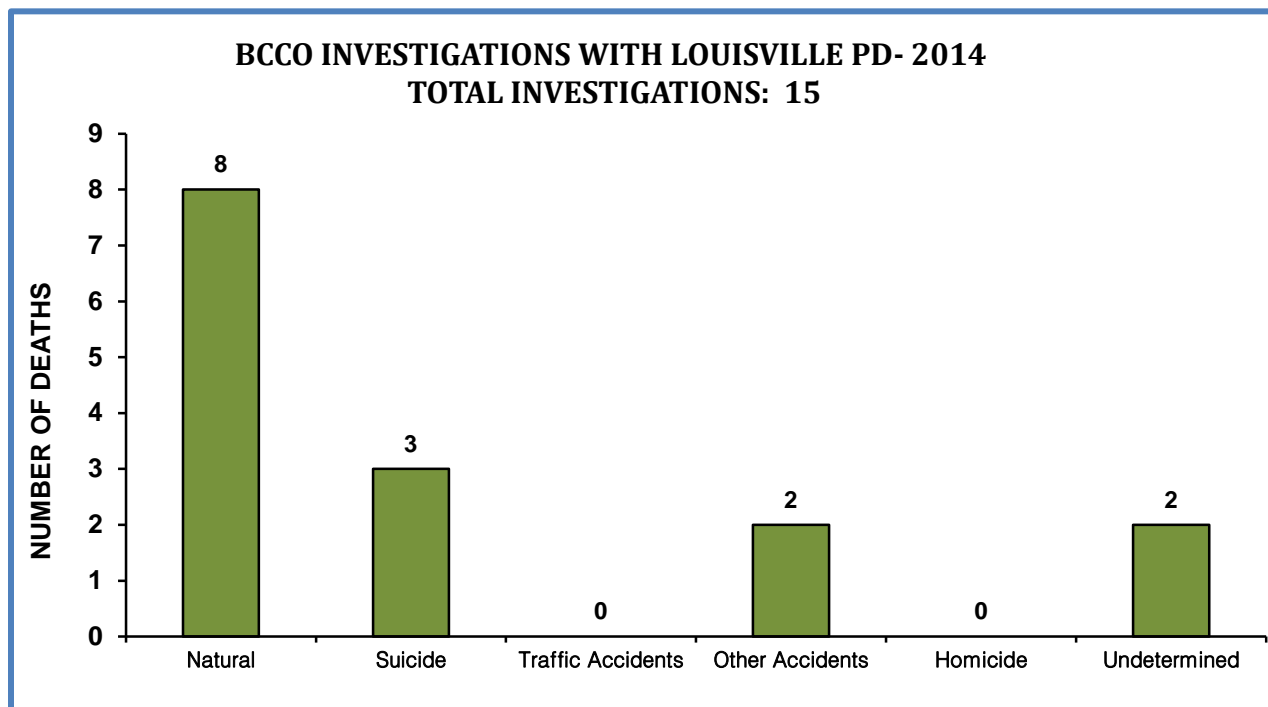


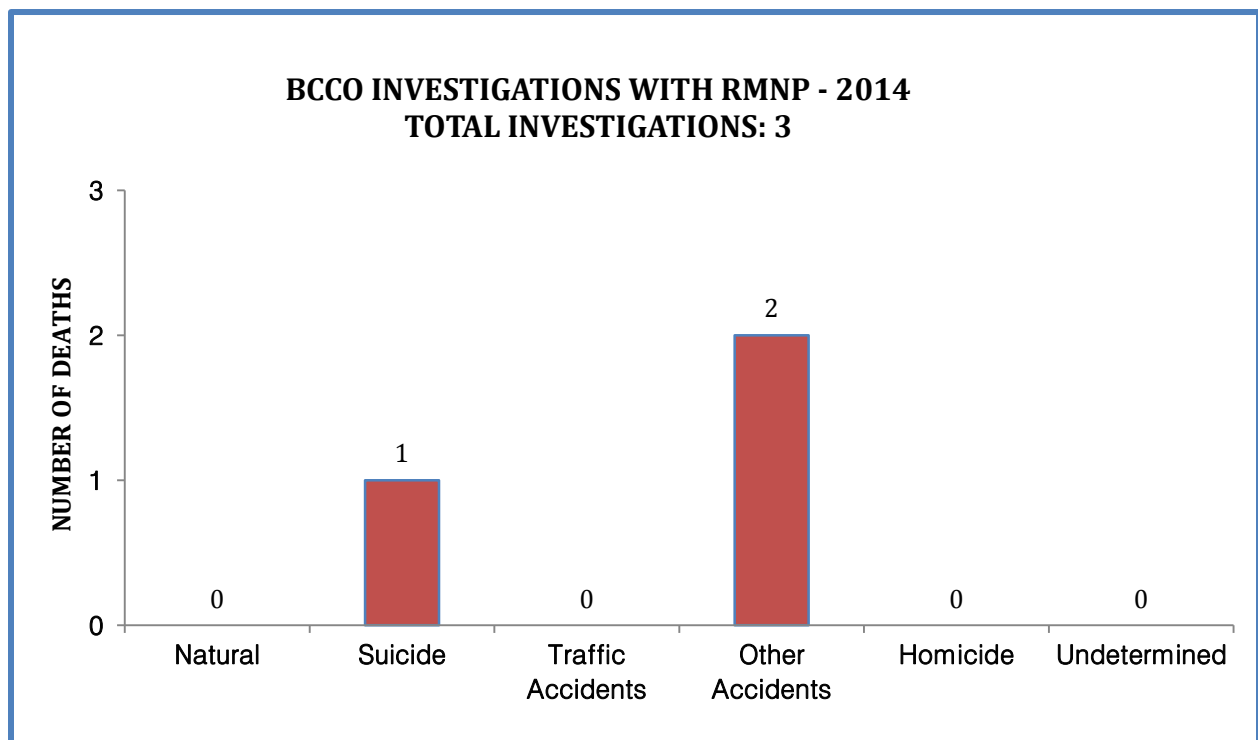
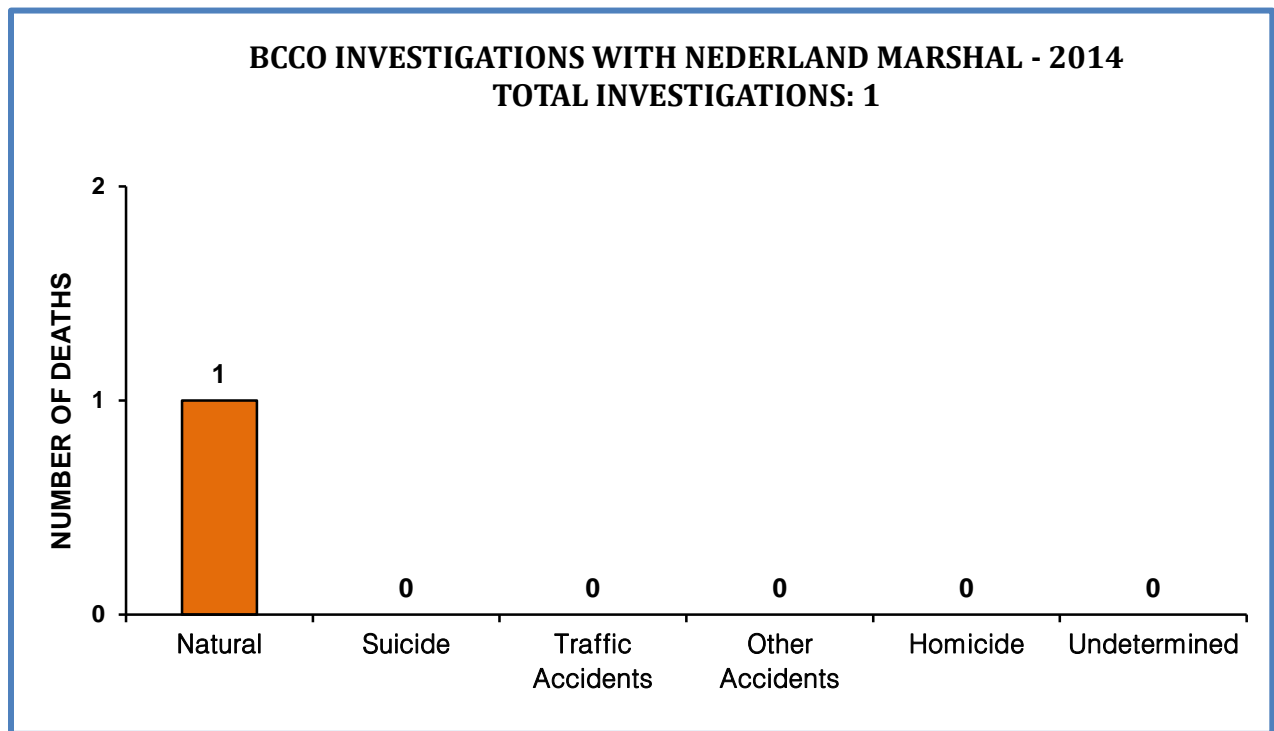
LONGMONT POLICE DEPARTMENT

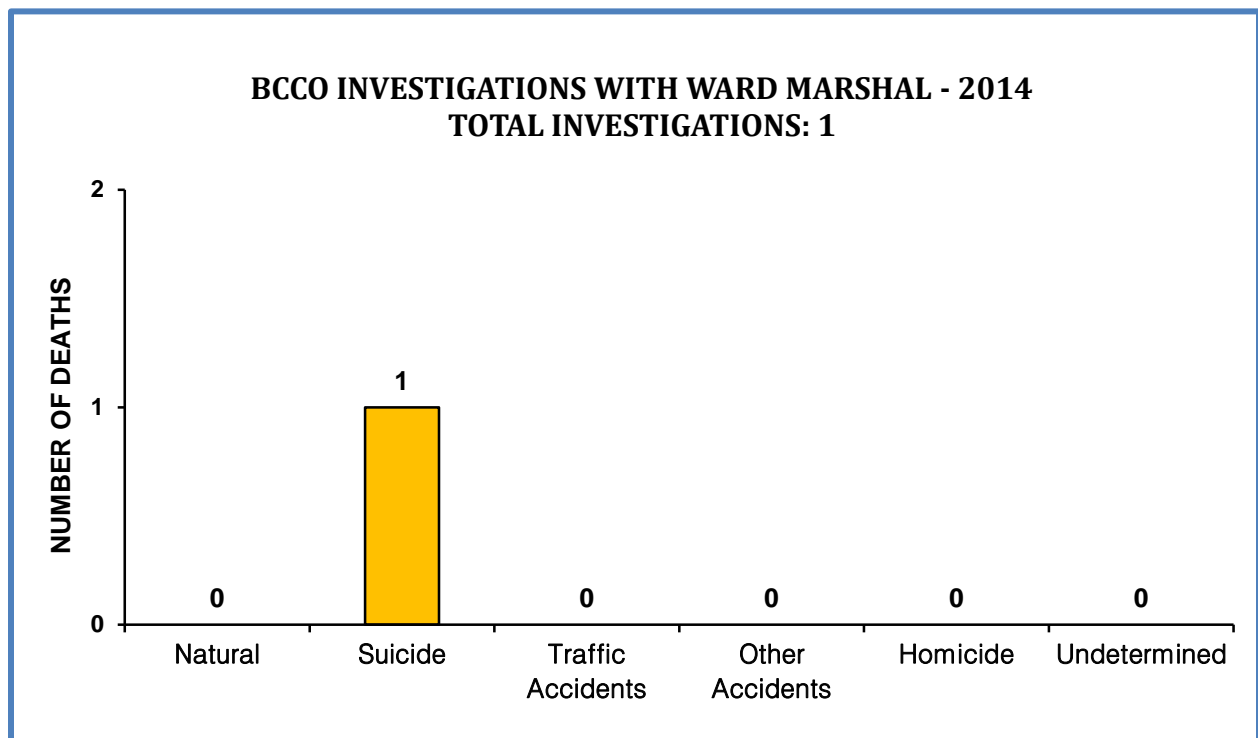
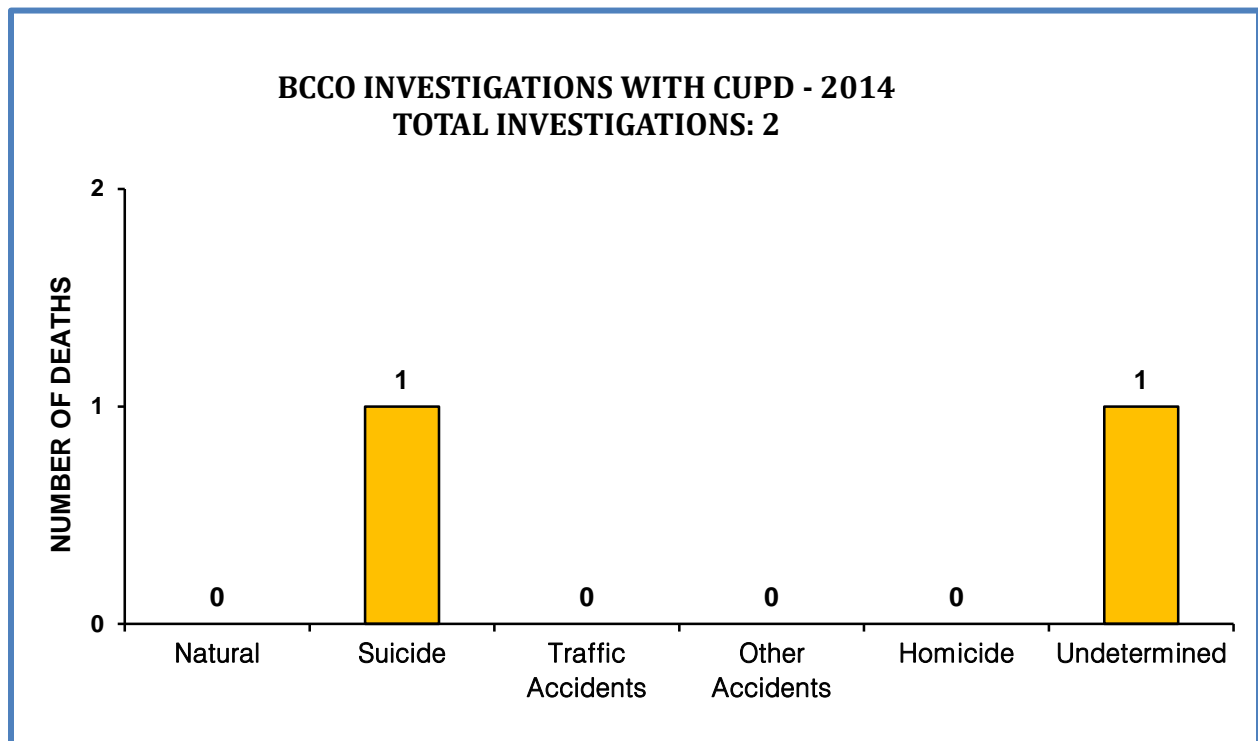


Note: *There was one investigation with Longmont Police Department that is not reflected in the above graph, this case was a fetal demise case in which a manner of death is not assigned.

LOUISVILLE POLICE DEPARTMENT







UNIDENTIFIED REMAINS

Boulder County Coroner's Office has investigated the deaths of the following individuals whose identities remain unknown.

UNIDENTIFIED BLACK MALE

Discovered: October 10, 1993

Approximate Age: 25-35

Height: 5'7"

Weight: 165-175 lbs

Eye Color: Brown

Hair: short curly black hair with bi-frontal balding.

Scars/Tattoos: On left eyebrow, obliquely oriented, well healed 17mm scar.

Clothing: Black socks; Short black sweat pants, brand name "Pro Spirit", overlaying a pair of long white sweat pants, brand name "Jerzees"; a white windbreaker-type shell with a hood and blue trimmed with zippers half way up front, brand name "Windcrest"; ankle length black hiking-type boots; and a blue mesh baseball cap with a New York Mets logo. Napkin with the logo "Dujour's Casual Café" was also found in his pocket.

Dental: Teeth in excellent repair with no dental work.



A well-nourished male of African descent was found near the base of the second Flatiron in Boulder, CO. Forensic Anthropology and Dentistry suggest he might have been a recent immigrant to America from North Africa. No obvious injury was found. An autopsy did not reveal cause of death. Some clothing and personal effects were found near him, but no camping gear or identification was present. He had a pair of thick-rimmed red prescription glasses.

UNIDENTIFIED CAUCASIAN MALE

Discovered: November 21, 1993

Approximate Age: 25-32

Height: 5'3" – 5'6"

Weight: 150-165 lbs

Eye Color: Unknown

Hair: Shoulder-length coarse straight dark blond to light brown hair

Scars/Tattoos: None

Clothing: T-shirt, blue denim jeans, white socks and white athletic-type shoes.

Dental: Teeth in extremely poor repair with dental work.

The remains of a mostly skeletonized Caucasian male were found on the North Slope of Gregory Canyon in Boulder County, CO. An autopsy did not reveal a cause of death, but the man may have been suffering from Chronic Iron Deficiency Anemia.

UNIDENTIFIED CAUCASIAN FEMALE INFANT

Discovered: October 12, 2001

Approximate Age: Infant

A Caucasian female infant was found placed in a dumpster behind a grocery store. The investigation is ongoing.

UNIDENTIFIED MALE SKELETAL REMAINS

Reported: November 8, 2013

Skeletal Examination Information:

Ancestry: European descent and/or African ancestry

Approximate Age: 32.59 +/- 5 years

Height: 5' 7.2" +/- 3.3 inches

Weight: N/A

Eye Color: Unknown

Hair: Unknown

Scars/Tattoos: Unknown

Clothing: Unknown

Dental: Maxillary left second premolar and mandibular left second premolar missing post mortem. The right mandibular third molar and both maxillary third molars appear to have never formed. Linear striations indicating possible biological stress during childhood when the adult teeth were forming.

These are skeletal human remains that were turned over to the Boulder County Coroner's Office from the Longmont VFW. The remains were reported to be that of a Native American Female, however an osteological analysis completed by Metropolitan State University of Denver-Human Identification Laboratory has concluded that the remains are that of an adult male approximately 32.59 +/- 5 years at the time of death and that the ancestry analysis indicates that the individual is not of Native American descent, although analysis is not able to definitively identify the ancestry. Analysis suggests that the remains are likely archaeological, although there is no definitive answer as to how long ago the individual died.

The interpretation from the Osteological Report states the following:

"The skeletal remains are consistent with a young adult male with antemortem trauma indicating interpersonal violence at some time in the life of the individual. The discoloration of the skeletal remains and root markings on the bones along with the lack of modern medical intervention for fracture repair and absence of evidence of modern dental work suggest the specimen is likely archaeological. The porotic hyperostosis, which was active at death, and linear enamel hypoplasias indicate biological stress during childhood when the adult teeth were forming. The ancestry analysis indicates the individual is not of Native American descent, though an unambiguous ancestry cannot be identified. Additionally, the postmortem breakage of several teeth, postmortem damage to several bones, and the missing elements (ribs and small bones) are consistent with the story told by the VFW "Last Man Standing Club" that the remains were dug up by one of their members many years ago."

Given that the specimen is likely archeological, it is not probable the identity will be determined, however until such time that an identification or additional information on where the remains originated from, the remains will be kept by the coroner's office.

REFERENCES

- 1 National Association of Medical Examiners, A Guide for Manner of Death Classification First Edition, February 2002, p. 3.
- 2 Colorado Dept. of Public Health and Environment, Violence in Colorado: Trends and Resources, University of Colorado, 1994, p. 123
- 3 Published online October 17, 2011 Pediatrics Vol. 128 No. 5 November 1, 2011 pp e1341-e1367 (doi: 10.1542/peds.2011-2285)